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CLINICAL LECTURE.

FLOATING KIDNEY.—NEPHRORRHAPHY.—ABSCESS OF THE STERNUM.—SCIRRHUS OF THE BREAST; REMOVAL.¹

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Floating Kidney.

Gentlemen: To-day I wish to show you a case which is rarely met with. It is a floating kidney which I intend to sew fast to the abdominal wall. The patient is a young woman, brought to us by Mr. Coleman, a member of the class, and his mother, Dr. Coleman, who has been the patient's physician, and who made the diagnosis. The patient is thirty-one years old. Five years ago, while reaching up for a heavy package of goods in the store in which she is a saleswoman, she suddenly felt something give way in her back, and she says that she also heard a distinct snap. This is very unusual. Patients frequently speak of the sensation of something giving away, but I have rarely known them assert that a snap was heard. The package slipped from her grasp, and she almost fell, and was unable to hold herself erect. Since then, to lift anything, no matter how light, has been a burden to her, because of the severe pain produced by the exertion. This pain is experienced in the right groin, in the back of the right thigh and even in the left. For the past three years she has practically been an invalid. At times there has been some disturbance of the urinary function. The urine becomes scanty and of a high color, but it has never been albuminous. Occasionally, also, there

are very marked digestive disturbances, such as diarrhoea, anorexia and indigestion. At these times she thinks there has been an increase in the size of the tumor, which can be felt in the right inguinal region. She is also of a distinctly neurotic disposition.

When I examined her she told me that if she lay upon her left side the lump would fall with a thud towards that side. This statement was verified by my examination. A tumor was discovered of the size and shape of the kidney. The hilum could not be distinctly felt, but we could feel a large artery pulsating, probably the renal. Professors Brinton and Parvin both examined the patient, and both felt the artery and confirmed my diagnosis. The tumor is very movable, and can be pushed up into its proper position, and even up to the epigastrium and to either side. On percussing the loins I found a certain amount of resonance, with a sense of diminished resistance upon the right side, but not the entirely clear tympanitic sound sometimes heard over the normal position of the displaced kidney.

The kidney is subject to two different forms of mobility. One is called the "movable kidney," when the organ lies in a bed of fat, and is readily moved about behind the peritoneum, but never leaves its envelope. This usually gives rise to but slight discomfort. The second form is what is called the "floating kidney," where the organ is entirely dislocated and merely held up by a meso-nephron or duplicature of the peritoneum and its vessels. The kidney gradually pulls upon this and thus gets farther and farther away from its normal position. Greig Smith asserts that such a condition is always congenital, but I do not believe this to be the case; in the first place, because it is rare to find it in a child, and, secondly, there is usually a history of some violent exertion or traumatism preceding its appearance.

Should a patient come to us with such a condition, what are our means of diagnosis?

¹ Delivered at the Jefferson Medical College Hospital.

In nine cases out of ten the patient is a woman, and in nine cases out of ten the trouble is upon the right side. Then we have a tumor which can be freely moved about without producing much pain. We may be able to make out the shape of the kidney, and feel the hilum and the artery. The tumor is solid to the feel. Then we discover all we can by means of percussion and bi-manual palpation. Such a condition may be mistaken for a tumor of the ovary, of the mesentery, of the omentum, a uterine myoma with a long pedicle, or impacted feces.

Suppose, now, I find that this is not a movable kidney? I should, then, close the wound in the back immediately, and perform a laparotomy to remove whatever abnormal condition I should find. This patient has also another trouble. In Douglas' *cul de sac* there is an enlarged ovary, tender and displaced, which is giving her some pain, and I may have to remove this by a later operation.

What are the indications for operation in these cases, and what is the prognosis? If there were no symptoms I should let the case alone. Still, a movable kidney, as it swings around upon its vessels and ureter, may become twisted, and cause a damming up of the urine with the production of a hydronephrosis. Thus, should we do nothing in such a case, the patient runs a considerable risk. If, in any case, the physical signs are those of a large cyst of the pelvis of the kidney, the organ should be removed at once by an abdominal incision. If there is no disease of the kidney, nephrorrhaphy, or sewing fast the kidney, should be done by a lumbar cut. The operation is not a very dangerous one. Dr. Thompson S. Westcott has collected for me a list of the cases which have been reported, a hundred and thirty-four in number. Of these, one case, which was operated upon by Ceccherelli, who fastened the kidney to the twelfth rib, died of pleurisy within forty-eight hours. Mr. Lawson Tait has performed this operation three times, and one patient died long after leaving his care, as he believes, from suppuration due to the operation. Hahn of Berlin reports one death in twenty of his own operations. So that the mortality is very small—about three per cent.

What shall I do in this case? If the kidney be found to be healthy, I would not think of removing it. Nephrectomy for floating kidney, though it has been often done, is in my opinion entirely unjustifiable

until nephrorrhaphy has been tried and failed.

Nephrorrhaphy.

The patient is placed on her left side over a pillow, in order to make the most room between the twelfth rib and the crest of the ilium, and the incision is made obliquely midway between the last rib and the crest of the ilium. Having cut through the abdominal walls, I shall reach the kidney and stitch it to the fascia of the posterior abdominal wall. For this purpose I shall use thoroughly boiled aseptic silk, as it will not be absorbed too quickly. One of the causes of failure in some of these cases is the use of catgut, which quickly disappears before the kidney has become sufficiently adherent. I shall insert my stitches, not through the perinephric fat, nor through the capsule of the kidney, but, as I have done in two other cases with admirable success, through the substance of the kidney itself, and fasten them to the lumbar aponeurosis. I shall then allow the wound to remain open and to heal by granulation. It is surprising how quickly a wound in the loins fills up. In one case in twenty-four hours the wound was completely filled up by the bulging tissues. The abdomen, as well as the back, must be carefully prepared, so that everything will be aseptic.

As the patient rests upon her side the last rib is distinctly seen, and here below is the crest of the ilium. The incision is midway between these points running diagonally forwards and downwards towards the crest of the ilium. Here is the anterior border of the quadratus lumborum, and here you see the peri-renal fat. I am now ready to have the tumor pushed up into position.

How shall I tell whether what I feel and see is the kidney or the liver? In one of my other cases I came upon the liver by accident, but no harm followed. One point of distinction between the two organs, normally, is that the liver moves with respiration while the kidney does not. But here we cannot depend upon this, as we have a floating kidney. But we can usually decide by the difference in color, and by the difference in the density of the two organs. Still, it is not always an easy matter to determine, but if you can pass your finger above the upper border of the organ you can determine whether in size, shape and position it is the kidney or the liver. I am now endeavoring to reach the kidney with my fin-

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ger in the wound. I can distinctly feel the psoas muscle, and now I reach an organ which, though I can feel but the upper surface, I am sure is the kidney. I shall tear through some of the peri-renal fat. It is said that absorption of this fat is often a cause of floating kidney, but in this, and my two preceding cases, I have found no deficiency of fat.

It is much more difficult to find the kidney in these cases than in an operation upon the kidney in its normal position. For example, last Saturday I did a colotomy, and the first thing I saw was the kidney. I have now harpooned the organ with a tenaculum as it lies deep in the abdomen and by it draw up the kidney and grasp it securely with this volsella. I shall lay bare the kidney as far as possible, to determine by touch and sight whether it is normal or not. My fingers here, instead of doing harm, will do good by exciting a certain amount of inflammation, which will aid in the formation of adhesions. As I draw the kidney down I can see the border of the liver moving with the respiration through the peritoneum. I can now feel the renal artery, and careful touch shows no disease. Next I insert my first stitch through the aponeurosis at the upper end of the wound and pass it half an inch deep into the substance of the kidney. There is surprisingly little bleeding following this suture. I am particularly careful to insert my stitches well into the lumbar fascia where I can secure a firm hold. Next follows a similar suture at the lower end of the wound and then two more anteriorly and two posteriorly. Now you will observe that I have the kidney well fastened, and I shall remove the volsella before I tie the stitches. I shall watch the urine very carefully for the next few days for any trace of blood. In my former two cases I did not find any.

I shall not sew up the lumbar wound, but shall simply dress it. I shall, however, insert two stitches ready for closure to-morrow if I so desire. When the patient lies upon her back, the edges of this now gaping wound will be in much closer apposition. My purpose is to get thorough union by cicatricial tissue, as in the radical cure for hernia. This wound will close, to a large extent, in twenty-four hours. As a dressing I place a large amount of bichloride gauze over the wound, especially at the back, and over this a piece of "rubber dam." On this is placed a pad of cotton, and the whole secured by a bandage binder fastened around the body.

In the kidney, as in other parts of the body, it is surprising how much violence can be done, if done antiseptically. Here I have made seventeen punctures into this kidney and yet expect no harm to result.

[NOTE.—The patient made an uninterrupted recovery, though she suffered considerable pain for the first few days.]

Abscess of Sternum.

The next case is one which you saw two weeks ago, a colored woman with a so-called "tubercular" abscess over her sternum. You will remember that after drawing out the pus I injected a solution of iodoform in ether. The cavity has refilled and I wish to repeat the operation to-day. If I find that this does not cure, I shall probably lay the cavity open and remove all of the dead tissue I find. This injection is frequently of great service. Recently in a little girl of fourteen with a large strumous abscess of the thigh, I aspirated the cavity and injected the solution once. Complete cure followed in ten days. Here is this woman's temperature chart. The highest temperature reached was 100.8°, the day after the operation. Since then it has ranged between 98½° and 99°. You will observe, now, how this abscess has been restored. Here is a mass, very soft, with no possible question as to its nature. The color of this pus has changed. It was a bright yellow before, but it is now dark-brown and almost without odor even of iodoform. The cavity has now been emptied by the aspirator, and I shall inject some of the solution, holding the handle of the syringe up so that no air shall enter. I have injected two and a half ounces which I press all over the surface of the cavity. The point of entrance is protected with a piece of rubber plaster.

[NOTE.—The wall of the "abscess" was so thin that it burst a few days later. At the next clinic it was laid open, freely scraped so as to remove all the tubercular granulative tissue, was then packed with iodoform gauze and speedily healed. The bone was not involved.]

Scirrhus of Breast.

I bring now before you a form of scirrhus of the breast, which has invaded the skin with the production of a small ulcerating nodule. The glands of the axilla are already involved, and I shall, therefore, remove them. Her history is as follows. She is fifty years old, married and has three

children. She says she was well until eight months ago. At that time she noticed a lump an inch above the left nipple and, at the same time, experienced severe neuralgic pains. This lump was the size of a small marble and was immovable and hard. As it grew the pain increased. For the past two months the pain has been excruciating; and when it occasionally ceases for a short time it is followed by a sensation of burning.

I must make a large incision in order to include both nodule and nipple. Having done this I proceed to enucleate the gland in the usual way. In this case I shall not remove the pectoral muscle, as the tumor does not seem to be at all adherent to the muscle. I have now removed the gland completely and shall proceed to clean out the armpit. To do this, I prolong my incision across the axilla, and I must exercise considerable caution because of the important vessels which are here. Formerly I carried this incision along the border of the pectoralis major, but I often found that the resulting linear scar acted as a band and prevented free upward movements of the arm. Of late I have been particular to carry it through the middle of the axilla and so have got rid of this hampering sequel to a great extent. I next dissect all the fat and the glands lying in its meshes, whether enlarged or not, for I fear even small and apparently healthy glands. The microscope would probably reveal the early stages of infection even in these. Always examine all the way up to the clavicle, for often the glands are infected even up to this bone. Next comes my usual double tubular and capillary drainage by rubber tube and horse-hair. I insert the sutures and apply the dressing which must include not only the chest but, by a second flannel binder, the arm too, so as to secure absolute rest.

[NOTE.—The wound was entirely healed in a week.]

A QUININE FACTORY IN BRITISH INDIA.—The *South of India Observer* states that there is a probability that the Wynaad Planters will start a quinine factory of their own, for the treatment of bark grown in their district. If by united effort such a factory could be established, it is thought that much benefit would result to the planter, in the saving of freight on a large quantity of useless material now transported.

COMMUNICATIONS.

DIPHTHERITIC PARALYSIS OF RESPIRATORY MUSCLES, INCLUDING DIAPHRAGM: RECOVERY.¹

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The occurrence of paralysis after diphtheria is a well-known clinical fact, although the precise manner of its causation is not as yet fully understood. It seems, however, that we are to-day, much nearer to an understanding than heretofore, the latest researches of Prof. Brieger² having shown that the micro-organism of diphtheria very probably causes the formation of certain deleterious substances, related to the peculiar group of bodies called ptomaines, the violent, deadly action of which Brieger has himself so successfully investigated.

The history of the case which I shall relate is a remarkable one; for there are comparatively few cases reported in which the diphtheritic poison caused such general paralytic symptoms, and still fewer in which the respiratory muscles—the diaphragm more especially—were implicated.

On November 7, 1887, I was called to see Nellie P., three years and ten months old. The little girl had been taken suddenly ill during the night with fever and vomiting. I found some diphtheritic patches on the tonsils, especially on the left side. The temperature was 104° F. On the fourth day (November 11) there was some exudation in the nostrils and swelling of the glands behind the angle of the jaw on the left side. On the sixth day fluctuation was felt, and an incision was made, quite good-looking pus escaping. The nasal diphtheria at that time was quite marked; still, everything went well: the abscess healed within five days and on the fifteenth day (November 22) I discharged the little one as cured.

On December 10, that is, eighteen days later, I was again called. I was told that the child's head dropped forward sometimes and was then swinging to and fro for some minutes. She had also been noticed to

¹ Read before the Section on Pediatrics of the New York Academy of Medicine.

² *Berl. Klin. Wochschr.*, Nos. 11 and 12, 1890.

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stumble and nearly fall occasionally. On examination I could not observe anything abnormal in the child's bearing. She carried her head erect and seemed to have perfect control of her muscles. She had no fever, her pulse was 90 and her heart-sounds were normal. Her palate was not paralyzed, sensation and reflex action being both perfect as well as speech and deglutition. I prescribed some extract of nux vomica and enjoined as much rest as possible.

On December 13 and 16 I saw her again, and was told that she was improving. Examination negative. No albumin in the urine, which I had examined on several occasions before. Treatment continued.

On December 22 I was called in great haste, and was told that the child was dying from suffocation. The report given with the message was, that on December 20 some cough had set in and the child had been seen to walk tottering for a short time. But she did not complain at all, was lively and played and even sang until the morning of the summons.

On entering the room I heard the child's rattling, and found her lying on her bed, exhibiting intense agony with peculiar respiratory movements which will be described hereafter. She was livid, almost blue, squinting with her left eye, and unable to move a limb, to raise her head or even to turn her body. She could not speak, in spite of efforts she evidently made to answer questions. I knew her to be a very intelligent child for her age and of an usually amiable disposition and lovable character; indeed, she has been and is to-day the pet of the family without being spoiled by it. But she now would not answer questions which I put to her myself, although we had always been good friends. Instead, she only gave me a half-sad and half-anxious look from her beautiful deep-blue eyes, which stared at me in a piteous way because of their unwonted squint.

Suddenly came on one of those terrible attacks of which her mother had just told me and which she, quite appropriately I think, called "storms." The rattling in the girl's chest became extremely violent; apparently, there were attempts at coughing, but no sound except a low gurgling in the throat was noticeable. "The cough was aphonic and ineffectual; it lost almost entirely its explosive character," as Pasteur¹

has well put it. The child's features did not express much of the anxiousness she must have felt with every attack; only her tearless eyes, staring fixedly from her livid face showed the extreme dyspnoea from which she suffered.

On introducing my finger into the throat, I found it filled with mucous secretions, which I removed. Gradually the violent action ceased, but respiration remained abnormal and was evidently insufficiently performed, and the rattling continued.

I found the temperature to be 100.5° F., the pulse 120 and the number of respirations 52, with no albumin in the urine.

I now had the child stripped to make a thorough examination. On inspection the respiratory movements of the chest were seen to be limited; they were mostly confined to the lower portion. Those of the abdomen were peculiar; it was drawn upward during inspiration and returned downward quite suddenly on expiration.

On percussion no dulness was found anywhere and auscultation revealed only numerous râles, mostly large, all over the chest, but no bronchial breathing.

For some time I was puzzled what to make of the case, how to account for the severe dyspnoea in the absence of any serious bronchial or pulmonary lesion. The condition could not be due to any cardiac complications, as the pulse, although quite accelerated, was pretty good in quality. Taking in consideration the complete paralysis of nearly all the voluntary muscles of the trunk and extremities, I studied once more the movements of respiration. It was evident that the upward and downward movement of the abdominal parietes and contents was performed in an entirely passive manner. The flabbiness of the abdominal muscles was clearly visible, replacing the normal tension we are wont to see in a well-nourished child. Furthermore, the abdomen, instead of descending and protruding with the inspiratory movements of the diaphragm and returning to their original position in an upward direction, with expiration, showed just the reverse type; the conclusion was evident that the diaphragm did not perform its function. This important muscle was paralyzed!

Beside this serious condition, it was evident that the accessory muscles of respiration were unable to come into play, the pectoral muscles and the scaleni showing no contraction whatever. The child, being

¹ *Lancet*, May 14, 1887.

thus seriously handicapped, respiration and thereby life was only sustained by the limited action of the serrati muscles and the intercostals and the elasticity of the lungs and thoracic cartilages.

The movements of the abdominal walls and contents, in a manner opposite to the type we are accustomed to observe when normal diaphragmatic respiration is present, were unmistakably passive, due to suction, caused by the paralysis of the diaphragm. The limited expansion of the chest produced by the action of the external intercostals, the levatores costarum, the serratus posticus superior and serratus magnus muscles drew the diaphragm upward and the abdominal contents followed; the volume of respiratory space in the thorax was evidently encroached upon to a considerable degree by this arching upwards of the diaphragm.

That such was the real condition of things was put beyond any doubt by the peculiar movement of the abdomen as soon as inspiration ceased and expiration began. This movement was performed quite suddenly, and consisted in the falling backward of the abdominal contents into their original position by their own weight, as soon as the suction from above ceased. The expiratory muscles themselves, *i. e.*, the internal intercostals, the triangularis sterni and the serratus posticus inferior played a very unimportant part, while the abdominal muscles were completely paralyzed.

After the true condition of the case had been recognized, I reassured the almost distracted parents by telling them that I had hopes of saving the child, and instituted the appropriate treatment, namely, Faradization and the subcutaneous injection of strychnia.

The response given by all the superficial muscles of the trunk to the Faradic current was almost *nil*, only the superficial layers on the side and back of the thorax showing occasional fibrillar contractions. The main object was to stimulate the diaphragm to action again; this was sought to be accomplished by placing one pole on the side of the neck, over the course of the phrenic nerve, and the other directly over the under surface of the diaphragm, which was not at all difficult, since the flabby condition of the abdominal muscles allowed the electrode to be easily pushed far upwards under the ribs.

The solution for hypodermic injection was prepared by having dissolved five milli-

grams (gr. $\frac{1}{10}$) of the sulphate of strychnia in ten grams (150 minims) of distilled water. Of this solution 15 minims at first, but soon 20, 25 and 30 minims were injected, three times daily in the beginning and later on only twice a day, the doses being from $\frac{1}{10}$ to $\frac{1}{8}$ of a grain (0.0005 to 0.001 gms.) respectively.

No other medication was used except nitrite of amyl inhalations when the patient had severe spells of dyspnoea, and several enemata of glycerine when there had been no passage from the bowels for twenty-four hours.

The whole amount of strychnia given up to January 1—that is, the tenth day—was about three centigrammes (one-half grain), and the only symptom noticeable due to this comparatively large quantity in so young a child was strangury, which was observed three times altogether.

Recovery took place very gradually in the beginning; the only words the child muttered in the afternoon of the second day (December 23) were: "Oh! my neck! my neck!" After this she was able to answer questions slowly and indistinctly in a whisper.

On the fourth day the abdominal muscles showed the first slight reaction to the Faradic current, which had been used three times daily.

Not until the seventh day did her aphonic voice change partially into audible speech. On that day also the secretion of tears, which had completely ceased, began to show again. The child was awfully cross, and tried to hit and kick those around her, although hardly able to move her limbs. She even wanted to hold the spoon again and to eat unassisted, and did not want to be fed by others any longer. Her cough, almost incessant during the first days, had since December 27 begun to relax somewhat in frequency and severity, which had prevented her from taking food and drink in the beginning.

On this day she also showed the first signs of discomfort when the Faradic current came into play. From then until the fifteenth day, when Faradization was dispensed with, she cried out aloud almost incessantly during its use.

The only dysæsthesiæ the little patient complained of were peculiar feelings in her hands and feet. She said she felt as if there were crumbs of bread between her fingers and between her toes and it felt as if the soles of her feet were stroked with a fine

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comb. Later on she suffered intensely for a few days with general pruritus.

Her sleep was very poor, as is easily imaginable; for, even when she had no extreme dyspnoea, she coughed or, at least, tried to cough considerably and it was necessary for an attendant to constantly remove the thick whitish mucus which collected incessantly in her mouth and throat, and which she was unable to remove by hawking and spitting.

Decided improvement was noticeable on the eleventh day; the child slept four hours at one time and even tried to sing. She was able to sit up for the first time on the eighteenth day, and could stand on her feet on the twenty-seventh day, when she complained of pain in her left foot which persisted for a week. I saw her for the last time on January 23, thirty-two days after the beginning of the respiratory paralysis and two months and a half after she first fell sick with diphtheria. She was then in perfect health, did not squint any more and has been well until last month, when she was attacked with whooping-cough. From this she has been suffering for the last five weeks, but is improving now.

The gravest feature of the case, aside from the insufficient oxygenization of the blood, was the considerable accumulation of mucous secretion in the bronchial tubes and air-cells. As there was a great deficiency of muscular power, the efforts at coughing were unavailing, and there was consequently great danger of pneumonia and atelectasis from the filling up of the lungs with this mucus.

That the latter condition—that is, atelectasis—prevailed over the lower portions of both lungs was clearly evident on the third day. There was marked dulness, especially over the posterior regions of both lungs and some bronchial breathing, from the clogging of the secretion as well as from the want of expansion, the diaphragm, backed up by the abdominal contents encroaching upon the lower thoracic space. As the temperature ranged between $99\frac{1}{2}^{\circ}$ and $100\frac{1}{2}^{\circ}$ F., and rarely reached $101\frac{1}{2}^{\circ}$ F. the process could hardly be due to an active pneumonic infiltration. It was not until later that the temperature rose, and it was highest (101.6° F.) on the twelfth day. On that day the number of respirations, which had come down from between 50 and 60 during the first five days to between 35 and 45, ran up again to 62. The pulse also reached its maximum figure on that very day, beating 140 times a

minute, while before then it had ranged all the way from 135 down to 105, the average being 126. At that time also bronchial breathing, on the right side below, became very marked and the cough which had subsided considerably increased again in frequency and severity.

These dreaded symptoms, however, subsided within a few days. Dulness and bronchial breathing, which had both extended up to the middle of the scapula on the right side, disappeared above and only atelectasis persisted. This was appreciable as late as the eighteenth day, especially on the left side, where it still extended up to the eighth rib. On the twenty-first day respiration in the lower portions of both lungs became more and more vesicular in character and was soon fully normal. On January 22, just one month after the onset of the respiratory paralysis, the child was discharged from treatment.

In conclusion, I should like to make a few remarks on the clinical features of this serious complication, especially as compared with that absolutely fatal one: paralysis of the heart. While heart-failure, however, is to be dreaded only in the earlier stages of the disease, and rarely takes place long after apparent recovery from the original disease, paralysis of the respiratory muscles is mostly reported to occur later on. Heart-failure is rarely observed later than a week or two after the disappearance of the primary diphtheritic process. The time for respiratory paralysis is variously stated, but it occurs undoubtedly at a later period. In the case reported here, for instance, although various symptoms of transient palsy were observed during the three weeks following the primary diphtheria, the respiratory paralysis did not set in until a full month had elapsed.

In other cases reported—and they are very few in number—this grave symptom was seen at a still later period; as, in Pasteur's¹ case, 38 days, and, in Rothmann's² 41 days after apparent recovery from the diphtheritic attack.

Whether, however, cases of sudden death must always be due to heart-failure may be doubted; complete respiratory paralysis might perhaps produce the same effect. The extreme dyspnoea and the consequent feeling of suffocation would certainly be present in both forms of paralysis, with this difference,

¹ L. C. 4.

² *Deutsche Med. Wochenschrift*, 1885, p. 900.

however: In complete respiratory paralysis no respiratory movements are possible, although the heart may continue to beat for some time, while in the cardiac form respiratory efforts will continue for a short time after the heart has ceased to perform its function. But when both the cardiac and the respiratory centres are completely overwhelmed by diphtheritic poison, then death must be instantaneous, both vital functions ceasing at once and forever.

In the case under consideration the heart was beating almost normally, an increase in the number of beats being the only deviation from the normal. The quality of the pulse was good, its strength quite satisfactory. This would seem to demonstrate the fact that in spite of the circumstance that both centres lie extremely close together in the medulla, one may remain in an almost normal condition, while the other is so seriously affected as that life shall be endangered, rendering a fatal issue imminent. It is another illustration of the well-known capriciousness which is displayed by the diphtheritic poison in locating its lesions, following no certain course, passing by certain parts of the body and attacking others.¹

325 East Nineteenth Street.

THE DUTIES WHICH PHYSICIANS OWE TO PUPILS AND PATRONS OF OUR PUBLIC SCHOOLS.²

BY MARY E. GREEN,

CHARLOTTE, MICH.

Before the present century, the entire force of medical knowledge was concentrated upon the one subject, to discover some remedy to cure disease. This, once placed above other arts, has been relegated to a secondary place, and now the whole trend of scientific study is rather to the prevention than the cure of disease. It has been demonstrated that it is the better way to serve mankind than to neglect all hygienic and sanitary laws until disease has developed in order to try some new specific.

Possibly to question the public schools and their work regarding the best physical and mental development of the young, will raise a storm of indignation, but from

twenty-two years of practice and observation, I am convinced that much of the ill health in our girls and young women is due to the public school system, to the lack of recess and proper exercise, to the overcrowding in badly-heated and ventilated rooms, to the frequent examinations and the many studies required to keep up the grade work, all of which tend to develop nervous disorders.

We are united in condemning the causes of infant mortality, the impure drinking-water, the unclean streets, the cellars filled with decaying vegetables and the adulteration of food, as not only taking life, but deleterious to health. But are we as ready to denounce a system of school work that causes spinal troubles, injury to the eyes, nervous disorders, headaches and sleepless nights? School is a place where children are kept three hours in the forenoon and three in the afternoon with no intermission, and subjected to hard work and a most rigid discipline. Some years ago a Frenchman of some distinction spent a day visiting the schools of New York City. The rigid discipline surprised him. He asked if the pupils were subjected to that each day of their school life. When told yes, he gave his shoulders a shrug and exclaimed, "Why, such discipline as that would kill all the soldiers in the French army!"

Why is it that when the young man or woman enters college he or she learns for the first time that it is necessary to attend the gymnasium to practice athletic sports as a means towards preserving health? If the Delsarte system of gymnastics and expression make the young man or woman more beautiful and healthful, and the middle aged more graceful, why not give these theories to our children? Then when manhood or womanhood arrives, a perfect system of health is there also. There is much talk about enlightened motherhood and the capability of a woman determining the character and constitution of her child. It is a fine theory, but practically after the age of five years when the child becomes the property of the public schools, the enlightened mother has no more to say about studies, exercise, discipline and examinations than the most ignorant wash-woman. Almost the first thing done when a child enters school, is to begin competitive work, and the first thing one hears is a fear that the child will not pass his grade.

In children the nervous system is devel-

¹ Jacobi, *Treatise on Diphtheria*, 1880, p. 97.

² Read before the Michigan State Medical Society, June, 1890.

oped far in excess of the muscular system. The Spartans were wiser than we, and recognizing this fact, paid great attention to muscular development. The child remained with its mother till the end of the seventh year and then entered school where mental and physical training went hand in hand, both sexes being trained alike. The result was a very superior race of people.

How often doctors are asked why girls are not as strong as the mothers and grandmothers. Some of us are hobbyists, and we talk about late hours, bad food, heredity, tobacco, intemperance, corsets and a needed dress reform. But I believe that none of the things have as much to do towards enervating our young women as the present system known as the "cramming" system of education. The State wisely protects the child from labor in factories and mines, why not protect the brain, body and eyes in our schools?

The brain is subservient to the same physiological law as the other organs of the body. If it is carefully used, with intervals of repose, it acquires great vigor, but when overtaxed, may be so exhausted as to be incapable of thought and is often lost in utter confusion, a condition noticeable in children trying to do examples far beyond their reasoning powers, and during their frequent examinations. These children, confined by long hours of study with no intermission, are victims of a cruelty that is the duty of every physician to protest against and also against compulsory education that produces it. I do not believe that a reform can best be brought with physicians as members of school boards.

Why, do you ask?

Because from my position of observation it has appeared that when men are placed in office by the votes of the people they suddenly lose their individuality, their independence of thought, their convictions of right and wrong. To advance new ideas in opposition to old established customs would be detrimental to re-elections, and no officeholder, even on a school board, cares to behead himself officially.

Strange as it appears, when a child enters school there seems to be antagonistic forces at work between parents and teacher. The teacher becomes the sole authority as to what the child shall do and study. No matter what the condition of its health, or what its idiosyncrasies, it has entered the mill with hundreds of others to be ground through.

Some teachers have a theory that children grow one-sided at home, and it is their duty to develop them into well rounded-out men and women. The child becomes the piece of putty under the teacher's hands, and it is too often nothing but putty when the molding process is completed.

And so I think that many teachers believe that during school life the children must submit to all requirements. The greatest interest I have ever seen a teacher manifest in a pupil was to hold him up to grade work. They ought at least to be treated with as much consideration as a criminal who cannot be imprisoned by a judge without the sanction of twelve men. But the reputation of the school must be maintained, health or no health. Some time ago I heard of a talented young man who has been through the high school, had finished two years' preparatory course, a four years' collegiate course, three years' theological course. He preached and gave great promise but died of "stomach trouble." I think the truth was he died of nerve force.

Dr. William A. Hammond, the best authority in this country on nervous diseases, writes me, "In my younger days, nervous diseases of children were almost entirely unknown to me; now they are the most frequent." This he attributes to the present educational system, and further says, "I regard a recess of half an hour each forenoon and afternoon session as an absolute necessity for the health of the pupil."

Men of strong physique are making a demand for only eight hours of labor. Children already have six, and bring home an armful of books to complete the day's work. The school of the future should demand fewer hours of study, combined with industrial training. Teachers ought not to make rules depriving children of exercise or to keep them after school hours. I wish every school might be under the surveillance of a board of health, composed of practical physicians who should know every rule and restriction in the school. They should determine the temperature, ventilation, hours of study and light.

But we may discuss this question, we may combat it individually, we may acknowledge the detrimental effect upon the youth of our present school system, and unless there is a concerted action and a remedy suggested to correct the evil of over-education, nothing will be done. The high-pressure plan will continue, and we may, before long, find the

schools will be run by an electric motor power. If each succeeding generation is not better and stronger, with all our knowledge of disease and the disaster imminent from disobeying physiological laws, then are not our lives failures? It is as much our duty to warn people of the outbreak of an epidemic. Those who have strong convictions of right must be fearless in asserting them.

Over the entire universe one law is recognized—that of work and rest, that of the ebb and flow, of consumption and recreation, that of sleeping and waking. All living things obey these laws save man. Let us remember that the best fruit is not that which falls from the tree before its time. Neither is that the most perfect which is forced by hot-house culture.

CLEANLINESS IN MATERNITIES.¹

BY JOSEPH PRICE, M. D.,

PHYSICIAN TO THE PRESTON RETREAT, PHILADELPHIA.

There was a time when the abolishment of maternities was seriously considered, owing to the ghastly death-rate, and the reason of the general mortality was not appreciated. Now we are come upon an era of cleanliness, and the recoveries from child-bed are about taken for granted, barring complications entirely apart from a sanitary consideration. Not a great while ago there was an epidemic of typhoid fever in one of our great Eastern colleges. The students were prostrated in such numbers that the institution was closed. Those who were not sick or dead went home, while those who were brave enough to stay were daily treated to addresses, and listened to prayers upon the inscrutable providence of God. But after a while a sanitary investigation was made and a reeking sewer-pipe, emptying its filth and poisoning all within its reach, was found and repaired, the premises were disinfected and the visitation of Providence ceased. This is about the light in which puerperal fever was not long ago considered. We now know that in a majority of cases, especially in maternities, and illy drained and plumbed houses, it is due either to dirt or a poisonous miasm, deadly in the extreme or so attenuated as to produce annoying if not dangerous symptoms.

¹ Read before the Section on Medicine, American Medical Association, May, 1890.

It is not my intention, in this paper, to discuss the etiology or the treatment of puerperal fever, but rather to give, from my own observation and practice, what I consider essential to the avoidance of child-bed mortality and complications. First of all, the water-closets and bath-rooms should be entirely outside of the maternity proper. In even the most poorly ventilated houses, I have noticed an absence of all puerperal complications when there was no closet in the house, even where the other sanitary arrangements were most ordinary. I thus concluded that the water-closet or imperfect plumbing was responsible for a great deal of the annoying and dangerous complications noticed in the maternity of which I have charge. The directors of the Retreat accordingly had the closets and bath-rooms put outside the lying-in wards and separated from them by wide halls, through which a current of fresh air is constantly passing. The pipes in the closets are all set out from the walls eight inches, the bath tubs likewise; and all that is in any way likely to hold or retain dirt is rigidly excluded, even from these. The result was that the temperature charts of all the patients showed a lowering of their record, and a fever which was put down as due to the coming of the milk was shown to be avoidable by this improvement in the sanitary surroundings.

Of course all this must be prefaced by scrupulous cleanliness within the wards. In the first place, no bed or mattress is used a second time without refilling. Each ward, after it has been occupied about two weeks, is emptied and scrubbed twice, and allowed to air for two or more weeks, after which time it again comes into use. The wards are all treated thus in order. The patients on being introduced into the house are all given a thorough bath, their clothes are changed and they are not allowed to wear anything from the outside or to keep it within the maternity proper. On being brought into the delivery room, after having been again bathed, they are given a vaginal douche of bichloride, and are delivered antiseptically at every stage. Nothing ever comes into the delivery room that does not belong there; neither is anything allowed to be taken therefrom. After delivery the woman is removed to the ward. For napkins I use corrosive jute covered with corrosive cheese cloth. They are made for the Retreat in quantity, and are a great convenience, insuring entire cleanliness, and obviating the



necessity of washing linen or cotton napkins. These are used the first three days and are frequently renewed, especially immediately after delivery. The greatest attention is given to the linen of the patients and of their beds. No spot or stain is allowed, and when a garment is spotted or stained in the least it is removed. Clothing so removed is collected outside the ward in one of the free passages, where air is circulating constantly, and the basket for this purpose is emptied regularly every two hours by a laundry attaché whose business it is to look after this part of the work.

I shall make a still farther improvement in this respect as soon as the arrangements can be perfected, so that the collection of soiled linen shall be entirely without the building.

So far as the wards are concerned, they are ventilated by central passages at right angles having free communication with the outside air. In addition to this, each ward on one side has direct communication with one of the outside porches, enclosed simply by window walls for the admission of light and air. The laundry and all its appurtenances are outside of the maternity. The only defective regulation is that of the culinary department. This unfortunately is within the building. It should be either on the top floor or entirely outside, which is far preferable. These are the main points which I feel justified in referring to as connected with the results in the maternity within the last three years. There have been about 500 deliveries with no deaths of the mother and with a mortality of none in infants.

In private obstetrical practice, where a mixed population is absent, some of the details of the extreme measures for protection from dirt are, of course, not needed. Nevertheless, the general practitioner, if he would have a clear record and a clear conscience, must adopt a system of general cleanliness, which he must practice in a routine fashion, in order to avoid sooner or later a fatality where he will least expect it. He must see that the arrangement of the lying-in bed is not completed with dirty sheets, which soiling is supposed not to hurt, that no old carpets or table oil-cloths are used to protect the bed and that the patient has had no preceding vaginal irritative discharge; or if she has had, he should take measures to render it harmless, both for the mother's sake and for that of the infant. In these days any physician

who allows a child to be born with a purulent ophthalmitis is directly responsible for it, simply because with the proper precautions this can be avoided. A scrupulous observance of cleanliness in his own person, a change of garments and a bath after the handling of doubtful cases or of dangerous cases of fever or of sepsis before entering the lying-in room, will take away the chance of poisoning the lying-in woman and render ridiculous the custom still in vogue, by which a physician, when he has poisoned a series of women, seeks to escape the danger of further malfeasance by taking a vacation, instead of going to a Turkish bath and leaving his filth behind him and coming out a clean man.

The obstetrician who goes to an obstetric case without clean hands, clean finger-nails, clean linen and clean clothes runs just as much risk as the physician who recklessly prescribes a dangerous medicine and allows his patient to take it *ad libitum*.

The whole obstetric procedure has, for its first element of success, cleanliness; for its second element, cleanliness, and cleanliness for its every element—cleanliness of the patient, cleanliness of the physician, cleanliness of the nurse, cleanliness of the instruments when they are used and cleanliness in the after attention.

A final word in reference to the changing of napkins. These, during the first three days after delivery, should be changed every hour and burned. Soft, clean old linen should be employed, and due attention should be given to protect, by napkin or pad, the bed clothing which, of course, is usually not so abundant in the ordinary private house as in the specially equipped hospital.

INSANITY IN GERMANY.—The number of lunatics in the asylums of the city of Berlin, which was 1,582 in 1882-83, amounted to 2,528 in 1889. This shows a very large increase in the number of insane persons relatively to the growth of the population. In the period referred to the increase in the population was 22.49 per cent., whilst the increase in the number of lunatics was 59.79 per cent. The number of insane persons in confinement in the whole German Empire rose between January 1, 1881, and the same date in 1886, from 34,270 to 42,669, being an increase of 24.5 in the five years, as against an increase of 3.6 per cent. in the general population in the same period.

FOREIGN CORRESPONDENCE.

PARIS LETTER.

Treatment of Endometritis with Chloride of Zinc Pencils.—Precocious Genital Development.—Treatment of Orchitis with Chloride of Methyl.—Herpes Zoster Preceding Tuberculosis.—Action of Intra-Venous Injection of the Urine of Epileptics in Animals.—Treatment of the Convalescence of Influenza.—The Bulbo-Cavernous Reflex.—Suicide by means of an Ordinary Pin.

Dr. Dumontpallier has read before the last meeting of the Académie de Médecine a paper on his method of treating chronic endometritis by means of cauterization with a pencil of chloride of zinc. The conclusions arrived at are that the treatment of endometritis by means of chloride of zinc pencils, left in the uterine cavity, is the mode of treatment which gives the most favorable results. This treatment does not bring on peri-uterine inflammatory complications. The post-operative pain can always be minimized or rendered less sensitive by an abdominal hypodermic injection of morphia. The uterine mucous membrane is renewed shortly after the operation, while the return of the menstrual flow is often observed five or six weeks after the operation; and several patients have become pregnant; as to the different forms of stenosis, they must be treated by dilatation.

At the same meeting Dr. Crivelli, from Melbourne, presented photographs of a girl only eighteen months old, which showed a great development of the genital organs. The mammary glands have the volume of a young girl of fifteen to sixteen years; the mons veneris is covered with hair; the clitoris is very large and seems to be the seat of voluptuous sensations easily developed. The parts are red and inflamed, which gives one the idea that this extraordinary genital development might be due to masturbation. An examination of the internal organs has been impossible, yet the child has already menstruated three times.

At the last meeting of the Dermatological and Syphiligraphical Society, Dr. Du Cartal made an interesting communication on the treatment of orchitis by means of application of chloride of methyl. He treats his patient by taking a piece of cotton wool on

which a jet of chloride of methyl has been directed; this is then placed for 10 to 20 seconds on the scrotum on the affected side; the parts immediately contract, and the skin becomes cold and pale; care must be taken not to apply the drug too long, so as not to produce a mortification of the parts. On an average the treatment lasts a week, and in eleven or twelve days the patient is able to leave the hospital, while formerly his patients were kept for at least three weeks.

At the same meeting Dr. Lemonnier reported the history of ten patients, who, having had herpes zoster, became tuberculous. Five of them presented no trace of tuberculosis when they had their zona. Twice the tuberculosis appeared almost at the same time as the cutaneous eruption, once after six months; once after eight months, and in another case became affected with tuberculosis four years and a half later. An interesting fact is that one patient who had had an ophthalmic zona died from meningitis; while another who had presented a zona of the sciatic nerve presented genital tuberculosis.

Mr. Féré presented to the Biological Society the result of his very interesting experiments on the action of intra-venous injections of the urine of epileptics to animals. This experimenter has collected, first, the urine which has been last emitted by the epileptic patient before a fit; and the urine of the first and second emission consecutive to the fit. These urines have been separately injected to rabbits of the same weight, and the results obtained were the following:

The prepauxysmal urine in the dose of 20 cubic centimeters produced convulsions; and 25 cubic centimeters death. While the urine of the first micturition after the fit required 55 cubic centimeters to bring on convulsions, while 70 cubic centimeters produced a state of apparent death, but the animal came to after awhile. Finally the urine of the second micturition produced convulsions only at the dose of 125 cubic centimeters and death was brought about only after a dose of 145 cubic centimeters.

The conclusions arrived at are that the urine of prepauxysmal micturition, or urine of daytime, which ought to be as toxic again as the night urine as is found in the normal state, is almost thirteen times more toxic than the urine of the second part—paroxysmal micturition; while the day urine, instead of being less liable to produce convulsions than the night urine, is eleven times $\frac{1}{2}$ more

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This proves that the urine of epileptics, before a fit, contains a great quantity of convulsive and toxic substances which have a tendency to disappear after the fit.

Every one who has been brought in contact with the last epidemic of influenza has been enabled to observe the difficulty with which certain patients recover from the effects of that disease. A general asthenia is produced which involved almost every organ or system, and strange to say the extreme weakness in some patients was not at all in accordance with the severity of the disease. Dr. Huchard recommends a certain number of preparations which he has found very useful in the convalescence of that disease. In severe cases, he has used hypodermic injections of sulphate of strychnia; also caffeine, which, before acting on the heart, strikes the nervous system. The following preparation he recommends:

R Benzoate of sodium
Caffeine 22 32 grains

Divide into eight powders; four to be taken in the twenty-four hours.

He also recommends hypodermic injections of caffeine.

R Caffeine 4 parts
Salicylate of sodium 3 parts
Distilled water 6 parts

Each syringe-ful to contain 6 grains of caffeine. Six to eight injections should be given daily. Phosphorus preparations, among which the phosphates, in doses of one to two drachms a day, or preparations of phosphite of zinc are also to be recommended.

Dr. Onanoff has proposed at the Society of Biology, to designate, under the name of "bulbo-cavernous reflex," the sudden contraction of the ischio and bulbo-cavernous muscles which is brought on in man by the mechanical excitation of the glans penis; which he thinks to be of great diagnostic and prognostic value in certain diseases. To obtain this reflex, the index of the left hand is placed in the region of the bulb of the urethra; while with the right hand, the dorsal aspect of the glans penis is rapidly rubbed with the border of a piece of paper; this brings on a contraction which is soon felt by the left index. The results obtained by the author are the following.

In sixty-two normal adult subjects, who presented no trace of a nervous disease, the bulbo-cavernous reflex was always present. In old men, who have lost their vitality, this reflex is abolished or almost imperceptible. In three cases of common hemiplegia in which the genital organs had not been influenced by the disease, the reflex was found normal and not exaggerated. In two cases of transverse myelitis in the superior lumbar region, the reflex was certainly exaggerated, the erection taking place without the patient noticing it. In progressive locomotor ataxia, it must first be remarked that urinary troubles seem to have no influence on the bulbo-cavernous reflex; but when the reflex is found in those patients, their sexual function is intact or exaggerated, while, if the reflex is suppressed, they never have complete erections. Yet, it might occur that certain ataxic patients have observed a diminution in their genital function while the reflex still exists. In those patients, this diminution in the genital function will be a passing trouble, which will disappear under the influence of treatment; while if, with this diminution of sexual power the reflex is abolished, the impotence will be permanently established. The reflex was present in nine cases of neurosthenia with complete or partial loss of the genital functions.

The bulbo-cavernous reflex does not depend on the sensibility of the mucous membrane of the glans; for the author has seen an exaggerated reflex in ataxic patients, in whom sensation was greatly diminished.

The conclusion arrived at is, first, that in man in the normal state, such a reflex exists; second, in cases of interference in the genital function, the presence of this reflex indicates a dynamic origin which allows one to conclude to a favorable prognosis. The absence of this reflex will indicate an organic lesion, and therefore will confirm a grave prognosis.

Dr. Magnan has observed a case of suicide by means of an ordinary pen. The patient belonged to the class of anxious melancholics and had several times attempted to commit suicide; finally she succeeded, by means of a pen introduced under the left mammary gland. The pen was an ordinary one, an inch in length and penetrated in the sixth intercostal space, passed through the pericardium and injured the myocardium in different regions. Death took place by syncope, the cardiac arrest being due to the effusion of blood which

filled the lower three-quarters of the pericardium although no important vessel had been wounded.

Dr. Brown-Séquard remarked that this proves that acupuncture of the heart, which has been several times recommended, is a dangerous process.

PERISCOPE.

Dentition.

In a clinical lecture on teething, in the *Archives of Pediatrics*, July, 1890, Dr. Wm. T. Plant, of Syracuse University, says:

Though a physiological process, dentition is often attended with so much pressure and hyperemia as to cause both local and general symptoms. Some infants, indeed, get their teeth so easily that there are no signals of discomfort to herald their coming, but this is not the rule. The earliest local token of teething is a marked increase in the salivary and mucous secretions of the mouth. Until after the third or fourth month the salivary glands are almost inactive, but as soon as, or even before, dental activity begins, the mouth becomes full of fluid, which, as the infant has not yet wit enough either to swallow or eject, slavers over the chin and front of the chest. When the tooth has come through, the drooling becomes less, but increases again with a renewal of active dentition.

Fever is a frequent attendant on teething. It may be slight and of little account, but not seldom it is so high as to cause apprehension of danger. Perhaps its most distinguishing feature is its erratic course. It comes and goes regardless of the rules that ordinarily govern febrile movement. It may last but for a day; it may continue for many days; it may come and go several times before the teeth that caused it have erupted. The morning temperature may be as high as, or higher than, that at the close of the day.

Prominent among the phenomena of dentition are those that indicate an irritable and highly impressionable state of the nervous system. Unusual fretfulness; fits of screaming; eyes half opened and rolled upwards in sleep; night-terrors; obstinate wakefulness; jerkings of muscles; squinting; carpo-pedal spasms;—these and other like phenomena show that the "nerves are set on edge," and are not infrequently the forerunners of general and alarming convulsions. In the

hot months the most common and troublesome concomitant of teething is an intestinal flux. It is doubtless, so far as the teeth have to do with it, a result of reflected irritation. In summer it is the constant menace of the whole infant population, especially of bottle-fed babies in cities. Very often there is gastric as well as intestinal irritation, and the vomiting may be as annoying as the diarrhoea. Occasionally the onset of the disorder is so abrupt and the symptoms so violent and unrelenting, that it is properly called cholera infantum. In these, and even in cases that are less severe, there is extreme thirst and restlessness and rapid wasting. In cold weather the air tubes are much more likely than the bowels to receive the brunt of the reflected irritation. During dentition many infants are extremely sensitive to drafts and temperature changes. Another cause of taking cold is in the wetting of the clothing over the chest by the copious drooling. For these reasons, a "tooth cough" is extremely common in damp and wintry weather.

Less frequently than diarrhoea or bronchial catarrh is a disordered urination due to dentition. It may show itself under different forms. There may be a constant desire and effort to empty the bladder when there is nothing in it, or a spasmodic retention, or an annoying dribbling from incontinence. These symptoms will not often continue for more than a day or two at a time, but they may recur again and again before the teeth that caused them have erupted.

Now and then there is a troublesome otalgia, apparently the result of a reflected irritation, or an acute coryza, as shown by sniffling, sneezing, and red and watery eyes. In other cases the irritation expends itself in a surface eruption of eczema, or erythema, or urticaria, especially about the face and scalp—the "tooth rash" of nursery talk.

In regard to treatment Dr. Plant says: Having local and general symptoms, there must also be local and general treatment. When the drooling is copious, saturation of the clothing over the bosom should be prevented by a slaving-bib covered with rubber cloth or other impervious material. An over-secretion of saliva may be restrained by belladonna. As little as a drop, or even a half drop, of the tincture once in four hours may do as well as more. A teething child likes to press its gums against hard substances. The rubber ring now made for the purpose answers it better than the bit of

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wood or the coin of my infant days. The pretzel does very well also.

Until recently it was thought to be the most important part of the local treatment to cut the gums. It is now known to be needless and useless in nearly all cases, and possibly because of that it has fallen into an unmerited desuetude. Though it is rather the fashion now to condemn the use of the gum-lancet altogether, Dr. Plant is of the opinion that when a tooth is nearly through and the gum is seen to be tense over it, a free cross incision may liberate the crown and give quick relief to a suffering child. I would advise you not to use the lancet for a simple elevation of the gum, for that is no sure indication that the crown is near the surface. Such an appearance may come and go several times before the tooth has erupted; in fact, we may never safely predict the speedy cutting of a tooth unless its sharp edge can be felt beneath the gum. If there is gingivitis, scarifying the gum by light touches of the lancet will lessen the hyperemia and afford some relief.

For feverishness, nervous erethism, and fretfulness the bromides will render good service. From two to five grains in solution with syrup flavored with peppermint or winter-green, may be given and repeated as may seem necessary. If the infant is overwakeful an equal quantity of chloral may be given in similar solution. Aconite he recommends in small doses, repeated often. He puts from five to twelve drops of the tincture in a full goblet of water, and gives a teaspoonful every fifteen minutes for two hours; then every hour.

It must not be forgotten that a profuse diarrhoea with dentition is as exhausting and as certainly fatal, if not checked, as though due to any other cause. So, if the movements should exceed three or four in the day, they must be controlled.

In convulsions, if there is a tense gum over a crown that can be plainly felt or seen, there can be no harm in making a crossed incision through it. Very generally, however, other treatment will be needed, as the hot bath and the bromides, with or without chloral. When there are threatenings of convulsions Dr. Plant treats them with a light dose—one to three grains—of calomel, or hydrargyrum cum creta—two to five grains—with about the same quantity of powdered rhubarb, or followed after some hours by a dose of castor oil or castoria. Besides that, he gives one of the bromides

in such doses and at such intervals as may be necessary to control the convulsive tendencies.

Treatment of Gangrenous Bowel in Strangulated Hernia.

In an interesting paper in the *Edinburgh Med. Journal*, March, 1890, Mr. Francis M. Caird, F. R. C. S., Assistant Surgeon, Royal Infirmary, Edinburgh, discusses the treatment of strangulated hernia with gangrenous bowel. He says it is well to note the more usual sites and extent of the gangrenous areas. We may do this by observing the state of the bowel when exposed during operative interference, or by the examination of museum preparations. Femoral hernia, more especially, affords us an opportunity of inspecting good examples of this condition.

In regard to the question of position, it appears, from a study of the preparations and cases, to which he has had access, that we may find changes of a gangrenous nature situated as follows:—First, on opening the sac, and within it, a projecting knuckle of bowel may be met, gangrenous on its free border. Second, in dividing the constriction at Gimbernat's ligament, a similar condition may be found immediately beneath the point of stricture. Third, on pulling down the dilated vascular gut from out the abdominal cavity, it may be found damaged above the entrance into the sac. Fourth, but rarely, there may be a gangrenous patch on the collapsed portion within the abdomen beyond the sac. It seems that necrosis may occur at any one or even at all of these points.

If the bowel is now removed and spread out so as to expose the gangrenous areas more clearly, it may be noted that, if several be present, they occupy the positions already indicated, and are separated from each other by a distinct interval of comparatively healthy tissue. In regard to the extent of the necrotic change, one may note that the area which lay beneath the constriction is more or less annular in form. It resembles a signet ring, the bezel towards the free convex border of the gut and the ring, more or less complete, narrowing and tailing off towards the mesentery. The patches at the remaining sites are all more or less oval, run in the long axis of the bowel and lie opposite to the mesenteric attachment. Their extent will naturally

vary with the duration and circumstances of the hernia.

As to the treatment of the constricting agent, when one meets with gangrenous bowel in a hernial sac it is evident, Mr. Caird says, that it must be divided in order to judge of the condition of the bowel beyond. And in cases where the bowel has already ruptured, a stream of antiseptic lotion may be employed to thoroughly wash away fecal extravasations, and to disinfect while the stricture is divided.

There is now a choice of treatment. If the gut has not yet actually given way, the surgeon may return it, hoping that within the peritoneal cavity there is still a remote chance of its recovery. Or, again, he trusts to the local paralysis preventing it from straying far from the wound, he hopes that the local adhesions and effusion may shut off the damaged gut from the peritoneum, and that if, after all, death of the part should take place, that in this fashion general infection may be prevented, and at the outside only a fecal fistula ensue. Again he may prefer to stitch the gut to the wound, thus forming an artificial anus. Or, again, he may venture to carry out the more heroic resection of the gangrenous gut and by suture restore its continuity.

Mr. Caird adds yet another method which, under certain circumstances, might prove highly serviceable. It is, that in place of making an artificial anus or practicing resection, the rupture in the gut should be closed or its formation prevented by inverting the dead or dying tissue and suturing the sound wall of the bowel over it. The invagination thus carried out will be at the expense of the circumference of the gut, and must, of course, leave a somewhat diminished lumen.

The gut should be withdrawn, and closure effected by means of Lembert's suture. The needle must enter healthy tissue, and emerge in tissue that is fairly healthy, and the stitches should begin above and end beyond the gangrenous area, just as in suture of a ruptured bladder. The invaginated portions subsequently slough, and are passed by the natural channels.

The method is chiefly applicable to the small gangrenous areas which lie in the long axis of the gut. It might also save resection in bullet and other wounds of intestinal tract. It can be carried out rapidly, there being nothing to cut away, and therefore no hemorrhage to control. The stitching is

rendered much less troublesome by the use of Dr. J. M. Cotterill's intestinal needles.

As to the evil results which may follow from such treatment, Mr. Caird says, one dreads the formation of a stricture. However, in the case of suture in the longitudinal axis of the gut, where not more than one-third of the circumference is included, one would probably have little to fear on this score. Little or no contraction is likely to follow after the primary suture. And, again, if we are dealing with the small intestine, the fluid character of the contents is not likely to give rise to much trouble, even with a somewhat narrowed lumen. On the other hand, where there is a damaged ring of tissue, general contraction giving rise to a marked stricture often ensues.

The method described is an attempt to apply Nature's teaching. To what extent we may venture to diminish the lumen of the bowel, can only be learned by vivisection or the study of cases in man. In every case a careful selection of some one of the various plans of treatment must be made, and this can only be determined by the condition of the patient generally, the local state of the parts and the resources of the surgeon.

Oil on Waves.

In a lecture on "Foam," Lord Rayleigh insisted that foaming liquids were essentially impure, for pure liquids will not foam. For instance: neither water nor alcohol can be raised into a froth, although a mixture of the two may be to a certain extent. The addition of gelatine to water in the proportion of 1 in 100,000 develops the foaming quality quite noticeably. Of course, the best-known foaming liquid is a solution of soap, such as the children use for blowing bubbles. A liquid foams when its films have a certain durability. In all liquids these films exist, since a bubble as it rises is covered with a thin film. Now, the most striking property of films is their tendency to contract, and they may be regarded as being in the condition of a stretched membrane, as of India-rubber, with the difference that the tendency to contract never ceases. An air-bubble will force the air back through the pipe, and a loop of silk floating on a film will be forced into a circle the moment the film inside it is ruptured. Oil forms a film on the surface of water, and covers it entirely, even if the mass of the oil be col-

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lected into drops. This is well shown by dropping a particle of oil on to a vessel of water lightly covered with sulphur flour. The sulphur will be immediately driven to the edge by the spreading film. The reason of this is that the tension of the water-air film is greater than the combined tensions of the water-oil and oil-air films, and consequently pulls out the oil-film. It is possible to reduce the surface tension of water by mixing it with various substances, such as ether and camphor. Camphor scrapings placed on the surface of pure water enter into vigorous movement, because the dissolved camphor diminishes the surface tension of the water; but if the water be contaminated by the least quantity of oil or grease, the motion ceases. Lord Rayleigh made several experiments to find what thickness of oil-film would accomplish this: he found it to be about $1\frac{1}{2}$ millionth of a millimeter. This thickness bears to an inch the same ratio that a second of time bears to half a year. Lord Rayleigh explains the calming action of oil on the sea as follows: as the waves advance, the surface has to submit to periodic extensions and contractions. At the crest of a wave the surface is compressed, while at the trough it is extended. So long as the water is pure, there is no force to oppose this; but, if the surface be contaminated, the contamination strongly resists the alternate stretching and contraction. It tends always, on the contrary, to spread itself uniformly, and the result is that the water refuses to lend itself to the motion which is required of it. The film of oil may be compared to an inextensible membrane floating on the surface of the water, and hampering its motion.—*Science*, June 27, 1890.

Cholera in Europe.

Whilst watching to see whether cholera was this year to advance from Mesopotamia and Persia by means of the lines of human intercourse between those countries and Southeastern Russia news has come to the effect that Western Europe is again the seat of this disease, an outbreak having occurred in one of the Mediterranean provinces of Spain—namely, Valencia. The first place affected was the village of Puebla de Rugat, with a population of some seven hundred inhabitants, where the disease is believed to have commenced on May 13 last. At first came the usual denials as to the true charac-

ter of the malady; then it was admitted that it was choleraic in character; and, lastly, came an official announcement by the Minister of the Interior to the Senate to the effect that cholera did certainly prevail in Valencia, but that it was not Asiatic cholera. This last statement involves an extremely interesting consideration. The commencement of the disease in Puebla de Rugat is said to have corresponded with the excavation of a considerable amount of drain-sodden earth in the village; and, remembering the history of the province of Valencia during the European epidemic of 1884–1886, it is quite possible that we may here be seeing a recrudescence of the disease, owing to the circumstance that the contagium of cholera, which had been lying dormant in the earth, has by reason of the excavations and consequent exposure to sun, rain, and other new conditions, become again active; and in this very limited sense the present outbreak may fairly be regarded as a local cholera, rather than a cholera newly imported from Asia or elsewhere. But the history of the disease in Spain is essentially that of true cholera, as that term is generally understood. By June 15 it had steadily spread, until out of one hundred cases there had been twenty deaths. In the meantime, also, it had extended to other places near at hand, and notably to Montichalvo, where the well-known virulence of real cholera showed itself by causing seven deaths out of a total of fourteen attacks. People now fled from the affected localities, and in this way further diffusion of the disease occurred, one death taking place at Albaida, and one attack being reported from Valencia itself. The latest intelligence refers to sanitary cordons around the infected villages, from which two-thirds of the population had already escaped; to certain operations intended to secure the burning of the polluted soil excavated at Puebla de Rugat; to quarantine restrictions against arrival from Valencian and other Spanish ports; and to measures of sanitary reform after the mischief has been induced. Some diminution in the epidemic is also reported. Recalling the circumstances of the last epidemic in Spain, it should be remembered that some 300 cases of cholera occurred in that country in 1884, the main outbreak being in the province of Alicante, but Valencia also suffering. This occurrence was followed in 1885 by a widespread epidemic which, according to the official returns of the Director-General

at Madrid, caused 338,685 attacks and 119,620 deaths, the deaths in the province of Valencia amounting to 21,612. And lastly, cholera still prevailed in certain parts of Spain during the early months of 1886. There is thus an interval of four years between the former and the present outbreak; and it is not difficult to conceive that the link between the two may have remained on Spanish territory.—*Lancet*, June 21, 1890.

Meningitis from Ear-Disease.

At the meeting of the Boston Society for Medical Improvement, April 14, 1890, there was an interesting discussion on meningitis due to ear-disease (reported in the *Boston Medical and Surgical Journal*, June 26, 1890), in which Dr. Spear referred to the feeling of hopelessness of recovery where meningitis sets in. He excepted cases coming early under treatment. He recalled three cases of meningitis, from extension, in which recovery took place after careful watching and very heavy dosing with bromides and morphia. Perhaps he should except one other case in which there was partial unconsciousness noticed at the first examination. The patient failed to react to most of the tests. He answered to his name, but failed to give any history, and in a day was entirely unconscious, remained so a week and went on the usual course. He made a full and complete recovery not only from the meningitis but from the hypostatic pneumonia which developed from his long lying in bed, and also recovered from a severe hemorrhage of the lungs which followed that pneumonia. The two other cases were of simple meningitis following acute inflammation of the middle ear, which also recovered under anodynes pushed until the heavy bounding pulse was noticed to fall, and followed by stimulants. He thought the importance of recognizing a meningitis is clearly shown by an experience which he had in consultation with several gentlemen in Boston about two years ago. It happened in this wise: A patient was referred to him for pain in the ear. On examination he found a slight congestion and thought it necessary to do paracentesis of the membrana tympani to relieve the pain. The patient refused to submit, however, and went away. In three weeks he returned with the same story of pain in the ear, and had suffered just as in the two weeks previous to his first call. Dr.

Spear insisted upon his submitting to some treatment. He went home. The third time he heard from him was in consultation with his family physician and another gentleman. He found him unconscious, comatose and practically moribund. He examined the ear then and found the membrana tympani was perfectly normal, except that it was thickened. There was no perforation, no purulent discharge, no outward evidence of any disease of the ear, but remembering the history of an acute inflammation beginning and following it along, he knew the cause of the meningitis, but the case had been treated by a general practitioner as one of neuralgia. The patient died the next day after the consultation. The character of that case is one found not infrequently and gives us the most difficult cases of acute inflammation of the middle ear. It occurred in an ear previously thickened by chronic inflammatory processes, where in such cases, as one can easily see, an acute inflammatory process cannot cause the very thick membrana to rupture so as to extend outward, and extending in some direction often takes a course through the tegmen tympani to the meninges.

Nitrate of Potash in Intermittent Fever.

Dr. J. D. Hunter writes from New Orleans to the *North Carolina Medical Journal*, June, 1890, that to answer fully and specifically the great number of communications received from physicians throughout the country, asking additional information relative to the use of potassii nitras in malarial affections, would necessitate the occupation of the greatest part of his time. He says, however, that he has treated more than two hundred cases of chronic chills of malarial origin, from a few months to years standing—many complicated with enlargement of the liver and spleen, dropsy, jaundice, etc., all more or less emaciated and anemic. Nearly every case was cured with a single dose of potassii nitras. From two to fifteen grains of the salt, according to the age of the patient, dissolved in a half ounce of water, and administered just prior to the chill or during its continuance, not only aborted or arrested the chill, but also effectually prevented its recurrence. In order to test the value of the remedy, he employed no subsequent treatment, but left the restoration to health (which was in nearly every instance

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rapid and satisfactory) to the *vis medicatrix nature*.

He is fully assured that from two to fifteen grains of potassii nitras will usually abort or arrest a chill arising from any cause. A large dose is not well borne by the stomach, and frequently, in his hands, caused most alarming and distressful symptoms, producing a prolonged depression of the heart's action.

Peritonitis in Women.

The *Boston Medical and Surgical Journal*, June 26, contains an abstract of a paper read before the Maine Medical Association by Dr. S. C. Gordon, in which he spoke of peritonitis in women as compared with that in men. He stated that while in the case of men peritonitis was usually fatal, in women the reverse was true as a rule.

The point was made that ulcerative appendicitis was much oftener the cause of this affection in males than in females, and that many of the cases of this disease attributed to women by statistical reports were really peritonitis from inflammatory affections of the sexual organs. The close proximity of the Fallopian tube of the right side to the appendix vermiformis renders the latter liable to frequent involvement in peritonitis coming from the tube and the general and local symptoms are so nearly alike that unless this element of tubal cause be recognized frequent mistakes in diagnosis and treatment will be made. Illustrative cases were cited. A striking feature in the differential diagnosis between peritonitis simulating true perityphlitis from perforation of the appendix or cæcum, is the remarkably low temperature in a large majority of cases; arising from the sepsis coming from the intestinal canal, because much less virulent and depressing to the nerve centres than that coming from the uterus.

In peritonitis from perforation there is usually the sudden attack of acute pain, violent retching and vomiting. In tubal cases there will be usually a history of discomfort and pain antedating the attack.

Consultation with Homœopaths.

The *Medical Standard*, June, 1890, devotes an editorial note to the inconsistency of certain medical men who are supposed to be strong supporters of the "Code of Ethics,"

and notes that the *Nashville Journal of Medicine and Surgery* says that at the last meeting of the Tennessee Medical Society a resolution was introduced by Dr. J. D. Cole, of Newbern, in reference to the construction of that part of the code looking to consultation with homœopathic or other irregular practitioners. Commenting thereon, the *Nashville Journal* says: "There can be no doubt but that certain circumstances might be looked upon as mitigating the stringency of this section of the code, as for example, the transference of a surgical case by an irregular to a surgeon, and it would seem that at times such a combination of circumstances have been taken advantage of, surgeons meeting and continuing in consultation with irregulars in cases entrusted to the former by the latter." The *Standard* wants to know wherein this position of the *Journal* differs from the much-opposed "emergency" clause of the New York code which led to the exclusion of the Medical Society of that State from the American Medical Association?

This inquiry is obviously intended not to get an answer, but to point out the manner in which certain men slip over to positions for going to which they have abused others.

Some Unusual Modes of Infection with Syphilis.

At the last meeting of the Association of American Physicians Dr. R. W. Taylor, of New York, reviewed the generally recognized modes, both direct and mediate, of origin of acquired syphilitic infection. He then reported cases in which the evidence was very conclusive that the syphilitic infection originated in the following ways: By means of chewing-gum; by one man to another; by means of an unnatural practice; probably from a cadaver; by means of a caustic-holder; by means of a handkerchief; probably from a bathing-suit; probably from a syringe; probably by means of a pair of drawers; by means of adhesive plaster, or through dressing of a wound; probably contracted in a water-closet; probably from a conductor's whistle; probably from a tongue scraper; probably from a towel; probably by means of a pillow; probably from a razor; by means of the fingers. All the foregoing cases, he said, carried with them important lessons, and many of them should teach

physicians that, besides treating their syphilitic patients, they should explain to them how they might become foci of infection, and make clear to them the means of preventing that great disaster to others.

Orexin.

Orexin, it will be remembered, was recommended by Professor Penzoldt as a stomachic some months ago and was described in the MEDICAL AND SURGICAL REPORTER, April 5, 1890. Since then other medical men have made clinical trials with it, one of the latest being Dr. Glückziegel. Out of seventeen cases of anorexia from various diseases, in which the compound was given, it had a good effect in fourteen, though this varied from strong stimulation of hunger to mere restoration to the normal. Glückziegel gave the pills uncoated with gelatine, and the intense burning sensation felt in the mouth if they were not immediately swallowed proved the superiority of Professor Penzoldt's prescription, which is

R Orexin hydrochlorate 30 grains
Extract of gentian
Powdered althea root, of each sufficient to make a mass, which is to be divided into 20 pills. Coat with gelatine.

Three to five of these pills are to be given once or twice a day with a large cupful of beef tea.

Another good mode of prescription is as chocolate-coated pills, which are very pleasant and effective in preventing unpleasant effects in the mouth.

Local Tuberculous Infection.

An accident which recently befell Dr. Gutzmann, of Berlin, may serve as a warning to surgeons and pathologists to be careful in handling tuberculous tissues. On February 19, while he was making a *post-mortem* examination on a patient who had died of acute miliary tuberculosis, the nail of his right middle finger was slightly raised from the matrix. He felt a little pricking at the tip of the finger, but could see no wound. After washing it in sublimate solution and alcohol, he forgot all about it, and used the finger in percussion without inconvenience. On March 20 it again became painful, and a tiny abscess was found under the nail. This was opened and the pus ex-

amined by Ehrlich's method, when three tubercle bacilli were discovered. The preparation was shown to several practitioners, who all identified the bacilli. The abscess was then scraped out and disinfected with alcohol. Up to the present there has been no lymphangitis or glandular enlargement, and no rise of temperature. Dr. Gutzmann regards the case as an example of local tuberculous infection.—*British Medical Journal*, June 21, 1890.

Microbes in Hailstones.

Bacteria of various kinds have been found in ice and snow, and Dr. Fontin, a Russian observer, has now proved that hailstones are not free from them. He has found that the water produced by the melting of hailstones contains on an average 729 bacteria per cubic centimeter. Neither yeast fungus nor mold was present, but nine different kinds of bacteria were found, five of which (*B. mycoides*, *liquefaciens*, *luteus*, *sarcina lutea* and *aurantiaca*) are already known. As the ordinary dwelling-place of the bacillus *mycoides* is the earth, we are confronted with the fact that microbes of terrestrial origin may be carried up into the air, and thus rain, snow and hail may be the direct means of conveying infection.—*British Medical Journal*, June 21, 1890.

Perspiration of the Feet.

Dr. A. E. Barrett, of London, recommends for the treatment of offensive perspiration of the feet the following prescription:

R Plumbi acet. ℥j.
Acet. destillat. ℥j.
Sp. vin. methyl. ℥ij.
Aq. ad ℥xvj
Misce; fiat lotio.

Essence of Pepsin.

The following formula for essence of pepsin is said to be better than that given in the National Formulary:

R Scale pepsin	1 troy oz.	10.00
Cinnamon water	2 fl. ozs.	20.00
Caraway water	4 fl. ozs.	40.00
Hydrochloric acid	1 fl. dr.	1.50
Elixir calisaya	2 fl. ozs.	20.00
Glycerin	16 fl. ozs.	160.00
Distilled water sufficient to make	4 pints	640.00

July 26, 1890.

Editorial.

III

THE MEDICAL AND SURGICAL REPORTER.

ISSUED EVERY SATURDAY.

CHARLES W. DULLES, M.D.,
EDITOR AND PUBLISHER.

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Do not abbreviate or omit words like "the" and "a," or "an."

Make communications as short as possible.

NEVER ROLL A MANUSCRIPT! Try to get an envelope or wrapper which will fit it.

When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.

The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

HOSPITALS FOR PHTHISIS.

There are times when certain subjects seem to take simultaneously possession of a number of men's minds at different places. One such is now when, on both sides of the Atlantic, the importance of establishing special hospitals for the treatment of consumption is being most earnestly discussed. In Europe this matter has been receiving most thorough and able consideration in the Society for Internal Medicine of Berlin, and the discussion has elicited the opinions on the subject of some of the most learned and distinguished medical men of that city. From the reports of this discussion we may gather much to aid us in this country in deciding what we shall do in view of the subject.

There are several ways of looking at the matter. First, what will be best for con-

sumptives? It is now well understood that consumption is curable in its early stages, and that nothing contributes so much towards recovery as a "long purse," that is, the ability to command the best skill, to live in the proper climate, and to have suitable food and surroundings. Unquestionably a man whose resources are such that he can command these things is better out of a hospital, even the very best, than in it. But by far the larger number of consumptives have very limited means, and not infrequently as the disease progresses they lack suitable food and shelter. Such patients are better in a hospital, provided the conditions are such as to promote their recovery. Now, in a large general hospital, the number of cubic feet of air for each patient is usually too small; the ventilation is not good; during the night and early morning the air is especially unwholesome; and, moreover, when not in bed, the patient must usually be in the ward or the corridors—he cannot get pure air in abundance and of a suitable temperature. General hospitals therefore are bad for a consumptive; nevertheless, doubtless, there are cases in which, even with their disadvantages, they are an improvement over what the patient can get outside of them.

Second, what effect has the presence of consumptives upon other patients in a general hospital? The effect can be harmful only. A consumptive will contaminate more air than a well person, and his sputa are liable to become dried, pulverized, and diffused around the room, forming a source of danger to all in the ward. Nor is the danger to other patients alone.

The problem seems to stand about thus: A large number of patients with consumption, who lack the means necessary to obtain suitable food, shelter, and medical treatment at their homes, could be cured in a hospital if the conditions were adapted to their requirements; but these conditions do not exist and, perhaps, are unobtainable in our crowded public hospitals. It therefore

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results that, except during temporary exigencies, a consumptive is better out of a general hospital than in it. Moreover, his presence in a general hospital is undesirable, as tending to retard the recovery of other patients and being a real danger to patients with bronchitis and pneumonia and to all others whose lowered vitality may tend to make them susceptible to tuberculosis.

On the other hand, the erection of special hospitals for consumptives, so arranged as to meet the wants of such patients, would be of very great benefit. There would be objections to answer and prejudices to overcome, undoubtedly; but these are inseparable from all advanced movements for the benefit of society. As to the increased cost which the erection and maintenance of such hospitals would entail, it should be remembered that the restoration to health and activity of a number of wage earners, many of them in the prime of life, would mean a great saving to society and would tend indirectly to balance the account.

We are happy to be able to state that a hospital for the study and treatment of consumption and allied diseases has recently been organized in Philadelphia, with a staff of earnest and energetic physicians and a body of trustees calculated to give it a very strong standing in the eyes of the general public. To this hospital we shall look for important contributions to the subject which we have just been discussing, and hope that it will strengthen our opinion as to the value of such hospitals and the wide field of usefulness which is presented to them.

EXPERIMENTAL RABIES.

Drs. Vestea and Zagari, who have for some years been investigating the action of the virus of artificial rabies in the laboratory of Cantani, in Naples, have recently published the results of some experiments in support of the theory that this virus has a peculiar affinity for the nerves, and that it seems to travel to the spinal cord and me-

dulla by the route of the nerves rather than by that of the veins of lymph channels. These experiments are described in *Fortschritte der Medicin*, Bd. VII, and are summarized in the *Centralblatt für Chirurgie*, June 28, 1890. The results are very curious in certain respects, as they showed that when the virus was applied to a small nerve filament far from the central system it was as sure to act as when an inoculation was made in the substance of a large trunk close to the spinal cord. This seems to present a contradiction to the claim of Pasteur that bites near the brain are more dangerous than those at the periphery because of their nearness itself.

MEDICAL EDUCATION.

A recent circular announces that the American Institute of Homœopathy, at its annual meeting at Waukesha, Wisconsin, June, 1890, upon the suggestion of its collegiate committee, representing the thirteen colleges of this school, voted to require a four years' course of medical study from all students entering its colleges after the session of 1891-92. The four years' course has been decided upon by the Illinois State Board of Health, and is acceded to by some thirty medical colleges in the country; but in many one of these four years may be of study in the office of a physician. Such a requisite is too vague and indefinite. The American Institute proposes to change entirely the character of this first year, and establish certain definite preparatory courses, which will be required of every student. These will include a thorough English education, a knowledge of physics, general chemistry, botany, biology, elementary physiology and easy Latin, sufficient to enable the student to understand medical terms and formulæ. This knowledge they can acquire in colleges, institutes of technology, academies, high schools, or even under an instructor. They will be required to pass satisfactory examinations in all these branches, which will be considered equivalent to one

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year of medical study, before entering upon the last three years, which must be passed in the medical school.

Such a course can hardly be regarded as an adoption of a four years' term of study, but rather as requiring three years and a good preliminary examination; but it would certainly advance the standing and attainments of medical graduates, and thus benefit the entire community.

It is interesting to note what the homœopathic schools propose to do in this direction, and we trust that their action may prove a sharp stimulus to some of the regular medical schools which as yet have not had the strength or the courage to place themselves squarely upon the platform of an advanced standard of medical education.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

INTERNATIONAL ATLAS OF RARE SKIN DISEASES. EDITED BY L. A. DUHRING, P. G. UNNA, MALCOLM MORRIS, and H. LÉLOIR. Parts I and II, 13x18 inches. With six full-page plates. Hamburg and Leipzig: Leopold Voss; London: H. K. Lewis; Paris: G. Masson; Philadelphia: J. B. Lippincott Co. Price, \$6.00 for 1890 (two or three parts.)

If the subsequent parts of the International Atlas of Skin Diseases are equal in beauty and value to the first two before us, the complete work will be unequalled in the field of dermatology. The Atlas is edited by four of the leading dermatologists of the world: Drs. Duhring, Unna, Malcolm Morris, and Leloir. The publication is a periodical *résumé* of clinical observations and progress made in dermatological science. The text is put in English, German, and French, and is printed in clear bold type upon heavy paper. It comprises, in a form as brief as possible, the history of the disease; where possible, the results of histological, bacteriological, and experimental pathological research; the author's views as to the nomenclature of the case; the differential diagnosis; and the treatment.

The illustrations are of a high degree of excellence and very graphic. The practical value of the work cannot be overestimated. Nearly every dermatologist in the course of his professional life, either as clinician or practitioner, meets with cases of skin disease which cannot be classed under any of the hitherto known types. But means of instituting a comparison of such cases with others, and of obtaining the opinions of the profession generally are, as a rule, entirely lacking. It is in this direction that the practical value of the Atlas will be most felt. The work will

not only be a valuable addition and ornament to any medical library, but also prove a faithful mirror of the most recent advances in the science of dermatology.

J. B. Lippincott Co. are the sole agents of this publication in America.

A MANUAL OF CHEMISTRY FOR THE USE OF MEDICAL STUDENTS. BY BRANDRETH SYMONDS, A. M., M. D. 8x6 inches, pp. 154. Philadelphia: P. Blakiston, Son & Co., 1889. Price, \$2.00.

This volume adds another to the long list of epitomes, which are in recent years taking such a prominent part in the educational outfit of the medical student. Exactly what is its justification it is difficult to say. The compiler remarks in his preface that the work is not a medical chemistry, although intended for medical students, "but takes up those parts of General Chemistry which it is necessary for them to know." The reviewer has had occasion several times before this to inveigh against these supposedly necessary contractions of our medical studies as tending to give rise to widespread but superficial knowledge of absolutely necessary branches of medical training. The only possible propriety for such works is their private publication for use by individual classes as outlines of the lectures of single schools, to serve as guides for fuller reading and study of the courses which they aim to epitomize. For use by the profession they are totally inadequate; for general use, even among students, their completeness is almost invariably fallacious. The volume in hand is no exception to these remarks. While the facts set forth in its pages are undoubtedly essential, there is much more in chemistry which should be regarded as quite as important by a conscientious student. Among its class the volume in question is a fair production; but it has not escaped numerous faults of commission as well as omission. Space will permit attention to but few of those which may be noted in a very hasty examination. On page 7 the reaction $2H_2O + Na_2 = Na_2OH + H_2$ should read $= 2NaOH + H_2$. Although considerable attention is called to oxygen, ozone, and hypochlorous oxide as supporters of combustion and oxidizers, and the liability of confusion is implied, no attempt at separation is made. SO_2 is regarded as the most practicable and as a "disinfectant sufficiently powerful for all practical purposes"—this is notably incorrect. In the derivation of phosphorus from the ortho-phosphate of calcium no explanation whatever is given of the name or nature of the primary product $CaH_2(PO_4)_2$ (acid phosphate), nor are the acid or basic salts of these acids referred to in this portion at least of the work. We cannot but hold that more truth is expressed in the foot-note on p. 30 than in the text, when the writer quotes in the former the opinion of the American Public Health Association in the mistaken claim that running water is safe as a potable supply in any instance. The value of microscopic and biological examinations of water and the explanations of methods are exceedingly unsatisfactory and misleading in several important points. In this portion of the volume even the chemical methods of investigation are so carelessly stated as to be practically useless to one seeking for working directions. Urinary tests are open to much the same criticism. Numerous other faults might be readily enumerated, but it will perhaps suffice to add in general that the book is very uneven in its arrangement and in the quality of work; that it is full of typographical errors and that its appearance is in no special manner creditable to the publishers.

CORRESPONDENCE.

A Word of Approval.

TO THE EDITOR.

Sir: The value of a medical journal depends: first, upon its contents; second, upon the paper, type and arrangement of the matter, and last, but not least, the index. It would not make a journal valuable to be issued on the best of paper, with clear type and unexceptional arrangement of material if that material was worthless, but it would add very materially to the good material to be issued on good paper, good type and properly arranged.

I have been making a comparison of the six medical journals that I take and find that the REPORTER takes the lead in the above respects.

Yours truly,

T. J. WHITTEN, M. D.

Nokomis, Ill.

[Once in a while we indulge ourselves in publishing a complimentary letter, and this one is so pleasant that we will share it with the readers of the REPORTER.—THE EDITOR.]

Hospital Physicians and Hospital Surgeons.

TO THE EDITOR.

Sir: My attention has been called to an editorial in the *Medical News*, July 19, under the heading: "The Relation of the Hospital Physician to the Hospital Surgeon," which is so astonishing that it seems to me it ought not to pass without comment. The Editor of the *News* refers to a case, which he says is within his own knowledge, in which a hospital physician had not enough confidence in his surgical colleague to put under his care a patient needing urgently—the physician thought—an abdominal section. The editor adopts so thoroughly the attitude of this physician as to speak of the surgeon with great contempt, charging him with "conceit," and with being capable of committing "professional murder."

As the ostensible point of attack in the editorial is the management of the general hospitals, it might be proper for those having control of them to reply for themselves; but a journal like the REPORTER, which represents the interests of the medical profession, ought to defend a member of it from charges which reflect not on him alone, but

also on every general hospital surgeon. I might criticise the conduct of the physician whose case is taken up by the *Medical News*; but I will let this go, simply asking: Is it fair to insinuate that many hospital surgeons in Philadelphia are not competent to do an abdominal section, or that one who should refer to them a patient seeming to need this operation would run the risk of becoming party to a professional murder? I do not believe it is; and I think you would do no more than justice if you would give space in the REPORTER to my protest, for myself and for the physicians and surgeons of Philadelphia hospitals, against the impressions conveyed in the *Medical News*. For one, I do not hold my surgical colleagues in such scorn as the editor of the *News* seems to, and I hope you will let the readers of the REPORTER understand that his utterances do not represent the sentiment of the profession in this matter.

Yours truly,

A HOSPITAL PHYSICIAN.

Philadelphia,

July 22, 1890.

[As our correspondent's question seems meant rather for the profession than for us, we leave the answer to it. Our own feeling may be inferred from the publication of his letter.—EDITOR OF THE REPORTER.]

NOTES AND COMMENTS.

Surgical Treatment of Appendicitis.

In a paper read at the last meeting of the Association of American Physicians Dr. Norman Bridge, of Chicago, said: Surgical interference is demanded in certain cases of inflammation in the region under consideration, whether they happen to be called typhilitis, appendicitis, perityphilitis, or by some other name, and the weight of first responsibility is on the physician more than the surgeon.

Surgery is imperative in cases of acute inflammation in the cæcal region, with rather protracted high temperature, and with distinct induration, sensitive to pressure, that does not show positive evidence of subsidence within two days, or three or four days from the beginning. This rule becomes more urgent if the induration continues to increase in size and sensitiveness after two days, or if symptoms of general peritonitis occur, or rapid, weak pulse, or rapid respi-

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ration. The vast majority of such cases if left to themselves eventuate in abscess in less than a week, and many before that time lead to mortal peritonitis. Some require operation in less than two days from the beginning of the attack, and most of them have perforation of the appendix as early as the beginning of the symptoms.

I am aware that a few cases here characterized do not require operation and would recover without it, but the number is so small compared to those in the greatest peril, to which it is a crime not to offer the benefit of surgery, and the danger of an antiseptic operation is so slight that they constitute no impeachment of the rule.

Operation is required in cases of undoubted severe acute inflammation in the region of the appendix, even though no particular induration is demonstrable, and in cases of acute localized peritonitis having its origin certainly at the appendix and causing marked constitutional symptoms. In the one situation there is almost certainly such violent inflammation of the appendix as seriously to threaten perforation, with all its dire possibilities; in the other, perforation has occurred and an abscess is probably forming. In the one case there should be laparotomy and extirpation of the appendix; in the other, laparotomy, extirpation of the appendix, if possible, and treatment of the abscess. Probably these two classes cannot be distinguished from each other; many of the symptoms of the one belong to the other. Practically, it is hardly important that they should be distinguished, as both abundantly justify surgical interference; the patients are in vastly less jeopardy with the operation, when carefully made, than without it.

Surgery is especially promptly required in that small class of acute cases in which a large, sensitive induration develops rapidly, with high fever and general evidence of severe constitutional disturbance. Here extensive deposit and large abscess are almost certain to be present, and the danger of early rupture into the peritoneal cavity is considerable, hence the necessity of prompt action.

Surgical aid is demanded in all cases which have advanced to the subacute or chronic stage with distinct induration of considerable size, or with any induration that steadily increases in size for many days, since in most such cases pus is present. These are the cases where sometimes weeks and months after the acute stage a tumor of variable size is found in the iliac region, slightly tender,

dull on percussion, and attended by a slight stiffness in walking dependent on pain in flexing the right thigh. Usually in such cases there are frequent exacerbations of moderate suffering in the affected region, often with slight fever, and disabling the patient for a day or two. Unless the tumor is very small pus is almost invariably found in its midst, the quantity varying from a few drachms to many ounces. The patient cannot be safe so long as an abscess is present in the neighborhood of the cæcum, but the danger is in proportion to the size of the abscess. Some portion of the cæcum must generally form a part of the abscess wall, hence the liability of rupture into this canal and into the peritoneal cavity.

Surgery is justifiable in all cases of undoubted chronic appendicitis with occasional exacerbations even if no induration is present. In all such cases we cannot doubt that the patient is in constant danger of perforation of the appendix and mortal peritonitis or perityphlitis—a danger greater than that involved in an antiseptically done laparotomy and extirpation of the little organ entire.

Administration of Creasote in Phthisis.

Dr. Alfred Eichler says, in the *Druggists' Circular*, June, 1890, that creasote is perhaps more prescribed now than at any time since it was first used in medicine. The medical profession the world over began some time ago to again use creasote as a remedy against the ravages of the bacillus tuberculosis, a fact well known to those of our pharmacists who enjoy a large prescription business. It has probably been noticed by many observers that it is quite a difficult matter to disguise the sharp and pungent taste as well as the objectionable smell of creasote effectively, frequently a matter of importance to the physician, it being only too often the case that consumptive patients are very fastidious regarding their medicines on account of the stomach rebelling quickly against nauseous drugs.

A formula much in use is the following, originated by Bouchard, of Paris:

R	Creasote	13.5 grams
	Tincture of gentian	30.0 grams
	Alcohol	250.0 grams
	Malaga wine sufficient to make	1,000.0 grams

This combines the restorative effect of al-

coholics stimulants with the antiseptic of creasote; unfortunately, the taste of creasote is much too prominent in this mixture for it to be agreeable to delicate patients. While it often may be convenient to combine the stimulants necessary to a patient with his medicine proper, I think that in this instance it will be better to leave out of the combination all spirits, as they only seem to diffuse the pungent taste of creasote. This pungency cannot be effaced by the addition of glycerin, bitters or other substances usually combined with liquors.

The ordinary prescription of many physicians, and a very good one at that, because possessing the effects of the two at present acknowledged best remedies for phthisis, consists in giving creasote with pure cod-liver oil, an addition which largely obliterates the taste of creasote, but introduces cod-liver oil, in itself objectionable to many. However, this may be remedied by emulsifying the oil. A better plan still and one which has been found to be quite effective, is to add to the finished emulsion of creasote and cod-liver oil, well flavored with some essence, a quantity of extract of malt, either the official or any of the thick extracts in the market, and also to add about two ounces of bitter almond water to each pint of the product. Thus we will have a liquid preparation which can easily be poured in and out of a narrow-mouthed vial. It would be represented by the following prescription:

R Creasote $\frac{1}{2}$ dr.
 Extract of malt 4 ozs.
 Bitter almond water 2 ozs.
 Emulsion of cod-liver oil (50 per cent.) 10 ozs.

Dose: One or two tablespoonfuls three times a day, after meals.

This form has been found to be an excellent and pleasant remedy, combining the effects of creasote and cod-liver oil, aiding digestion by means of the malt, and the almond water exerting a slight sedative influence upon the bronchial mucous membrane. The usual flavor for the above emulsion consists of the oils of orange, bitter almond and wintergreen.

Advantage may be taken of the fact that creasote can be completely disguised with oil of peppermint. One drop of creasote mixed with 30 grains of the oleosaccharate of peppermint of the *German Pharmacopæia* can readily be taken. This could be compressed into a pill or tablet. It is preferable, however, to prepare a mass with

gum tragacanth and sugar, suitably flavored with oil of peppermint, and then to divide this mass into troches.

Mackenzie's formula for carbolic acid troches (*U. S. Dispensatory*, p. 1542,) may be utilized by substituting creasote for carbolic acid, flavoring the mass with peppermint and dividing the same into troches or tablets of any size.

Capsules of creasote often prove of service; they can be dispensed and made up with any ordinary excipients. Creasote and cod-liver oil can be introduced into gelatin capsules and will keep for a long time. Quite often it will happen, however, that eructations and after-taste will follow their use and defeat the object.

Pills of creasote, when properly prepared, perhaps present the easiest method of administration. An especially good formula is the one combining balsam of tolu with creasote, as follows:

R Creasote 1 dr.
 Balsam of tolu 2 drs.
 Powdered marshmallow, sufficient.

Soften the balsam of tolu in a mortar with a small quantity of ether until of the consistency of a solid extract; to this add the creasote and finally enough powdered marshmallow root to make a mass; divide this into 60 pills. These may be coated with balsam of tolu after the formula given in the *U. S. P.* for phosphorus pills, or they can be silver-coated or dispensed in capsules. They will be tasteless and should be preferred to any ready-made coated pill. They agree with consumptive patients especially, and give in addition to creasote the stomachic and expectorant properties of balsam of tolu. In short, they present an excellent mode of administering creasote. The dose is one or two, three times a day.

Numerous other methods of exhibiting creasote could be devised; the above preferred methods, pill, troche or tablet and emulsion, however, will enable almost every one to take this efficient medicament, and will thus prove of service to a most unfortunate class of patients.

Corn Application.

In an article on the treatment of corns, in *Notes on New Remedies*, June, 1890, by Dr. H. M. Whelpley, the most popular "corn-cures" are said to depend upon the action

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of salicylic acid. Among the many therapeutic properties of this remedy is its power to disintegrate epithelial tissue. It is usually combined with cannabis Indica. The form Dr. Whelpley has found useful is nine parts of salicylic acid and one part of the extract of cannabis Indica and forty-eight parts of collodion. This is applied to the corn every night with a camel's-hair brush. The foot should be clean before it is applied and the mixture permitted to thoroughly dry before it comes in contact with clothing.

Salicylic acid corn plaster is made by melting six parts of resin and adding five parts of balsam of fir and then stirring in ten parts of salicylic acid as it cools. This can be spread on any suitable medium for a plaster. When used the corn must not be rubbed with the shoe.

Lanolin forms the basis of another salicylic acid plaster and cocaine is added with the idea of making it painless. To form the plaster, mix six drachms of salicylic acid thoroughly with ten drachms of lanolin. Dissolve five grains of hydrochlorate of cocaine in a small quantity of warm alcohol and mix the solution with one fluid ounce of creasote. Mix one-half ounce of melted white wax with one-half ounce of vaseline and add the creasote solution. To this add the cocaine solution and mix.

The following is given by the drug journals as useful:

B. Yellow wax	one ounce
Venice turpentine	two drachms
Acetate of copper	half a drachm

The wax and turpentine are to be melted and mixed, and the copper to be then stirred in, so as to make a plaster.

Lupus of the Larynx.

A case of lupus of the larynx has recently occurred in Professor Rydygier's wards in Cracow, and an account of it is given by Dr. Langie in the *Przeglad Lekarski*. The patient was a laboring man, aged thirty-two. He had suffered from a slight cough, hoarseness and difficulty in breathing for a couple of years, these symptoms having increased so much during the preceding two months that he had been obliged to seek medical advice. Externally, there was nothing to be detected, except that the subclavian lymphatic glands were much enlarged. On examination with the laryngoscope a gray

growth could be seen, with a rough, granular surface, extending from the base of the epiglottis into the right half of the larynx and involving the right vocal cord. On the left half of the larynx discrete tubercles, of the size of a millet seed, could be seen, and the rima glottidis was much narrowed. In consequence of the extreme dyspnoea from which the patient was suffering laryngotomy was performed, and then, as the growth appeared to be of a malignant character, the larynx was excised. Four months later the patient was fitted with a Bruns' artificial larynx, which proved quite satisfactory. The microscopic examination of the tumor showed it to be lupus.—*Lancet*, June 21, 1890.

Rupture of the Vagina.

The *Centrablatt für Gynäkologie*, No. 22, 1890, contains an interesting article by Dr. Himmelfarb, on rupture of the vagina; which is referred to in the *British Medical Journal*, June 28, 1890. Dr. Himmelfarb has carefully searched the literature of the subject, and discusses cases in his own experience. The great majority of cases occur, no doubt, in association with labor. The remainder appear less frequently due to the introduction of foreign bodies than to violent coitus. The former is the alleged cause in some cases really due to the latter. Rupture of the vagina in very old subjects during connection is a well-recognized injury. Dr. Himmelfarb describes a case, and a specimen illustrating the injury in age is preserved in the museum of St. George's Hospital. A similar accident in young subjects is hard to understand. Zeiss and Frank have recorded cases. Dr. Himmelfarb relates another where, in a healthy woman, aged 24, parametritis, peritonitis, and fatal pyemia followed coitus. The posterior wall of the vagina was found to be torn through. Connection had frequently taken place after the first occasion, when the pain was very severe, notwithstanding the suffering which it caused. Dr. Himmelfarb thinks that rupture of the vagina is probably more frequent than supposed in cases of sudden pain with no sign of injury about the external parts, and in such cases coitus is the true cause of the rupture. Dr. Frank, of Prague, described two cases before the German Medical Association of that city last autumn. In the first, the patient was 32 years of age; she recovered from the

injury, which was certainly inflicted during coitus. In the second, there was vagina duplex; the right half ended in a blind sac, the left communicated with the uterus. The hymen on the right side and the septum were lacerated in coitus.

In the REPORTER, March 22, 1890, Dr. Herbert A. Starkey, of Philadelphia, reported a case of complete laceration of the vagina, resulting in death. The rupture was caused by the forcible introduction of a man's hand into the vagina, in a fit of drunken and erotic passion. In that place it was stated that Taylor, in his work on Medical Jurisprudence, speaks of a girl eight years old, who was raped by an adult, and who lived for six days after the injury. The subject is one of considerable medico-legal interest.

A Long Fast.

The daily papers of July 16 reported that a man named John Roth had died July 14, at the County Asylum, Galena, Ill., having passed his sixtieth day of total abstinence from food of any kind.

The man was said to have been attacked by progressive paralysis two months ago, which incapacitated him from work, and soon made it impossible for him to eat. After a week of fasting he was brought to the County Asylum on May 23, and there lingered fifty-three days without food.

In reply to inquiries from the REPORTER as to the correctness of these statements, Dr. Hugh F. Gunn writes that they are substantially true; but that the man could take liquid or solid food if inclined to do so. He was in a state of stupor, from which he could be aroused, however, and at no time was any food administered by means of mechanical appliances. The man occasionally swallowed a little water. The account of the case rests upon the assertions of the Superintendent and the nurse at the Asylum. It is not as accurate and exact as might be wished, but indicates a long resistance to the effects of starvation.

Methylene Blue as an Analgesic.

The *Chemist and Druggist*, June 21, 1890, says: Since with the introduction of coloring agents as antiseptics what may be called a new step was taken, or rather, perhaps, a new source indicated, for remedial agents,

we may expect to soon find other substances obtained from the same class and brought forward as medicaments, the value of which may exceed that of the first found. We have now to note methylene blue which is claimed to possess analgesic properties. Those who have a great admiration for blue blood should seize the present opportunity of obtaining it cheaply since, besides relieving them of muscular or articular rheumatic pains it passes so rapidly into and through the circulatory system that an hour at the latest after the dose the urine is colored pale green, then bluish-green, and after four hours a fine aristocratic deep blue.

As is always the case with remedies recommended by the discoverer, no unpleasant secondary effects were observed even after continued use. Drs. Ehrlich and Leppmann, who investigated the medicinal properties of the substance, tried at first to administer it as a hypodermic injection, but without success, as they could not get a sufficiently strong solution.

Alvarenga Prize Awarded.

The Alvarenga Prize of the College of Physicians of Philadelphia, being the income of the bequest of the late Señor Alvarenga, of Lisbon, has been awarded to Dr. R. W. Philip, of Victoria Dispensary, Edinburgh, Scotland, for his essay on Pulmonary Tuberculosis, which will be published by the College.

Deceased Physicians of Virginia.

Dr. F. Horner, Editor of the *Virginia Medical Advance*, proposes in that journal, May, 1890, to present a brief sketch of lives of deceased physicians of Virginia. All Fellows of the N. E. Virginia Medical Society as well as the State Medical Society will confer a boon on the profession by contributing such papers to the *Advance*. If any there be unable to prepare sketches for publication in the *Advance* themselves will forward data that may be accessible to them to Dr. F. Horner, Marshall, Fauquier County, Va., that information will be gladly acknowledged and appreciated. The history of eminent medical men of colonial times as well as of the present century would prove interesting reading. Physicians of the former period were graduated from the Universities of London and Edinburgh and with

those of later times largely contributed to collegiate institutions in many States. Such facts ought to be preserved as an incentive to young members of the profession.

NEWS.

—Dr. A. Hamilton Deekens has removed to 1638 Franklin Street, Philadelphia.

—The New Jersey State Dental Society has just held its twentieth annual meeting at Asbury Park, N. J.

—Dr. G. Howard Beck has been appointed District Police Surgeon for the Ninth District, Philadelphia.

—Miss Nancy Goodrich died in Bloomfield, Connecticut, on July 13, of heart disease. She is said to have been 110 years old.

—Reports from Madrid, July 15, state that in the last two months there had been 445 cases of cholera in Spain. Of these 251 had been fatal.

—In the case of Dr. Pierce, Mayor of Hoopston, Ill., charged with illegal sale of liquor, as mentioned in the REPORTER, July 12, the jury disagreed.

—It was reported from St. Petersburg, July 18, that cholera was prevalent in Kowno and Vienna, and was spreading. Many fatal cases of the disease were reported.

—Dr. R. Stansbury Sutton, of Pittsburgh, has just completed a seventh and most successful year at his private hospital for women. He treated there during the year just closed eighty-five patients.

—Dr. H. W. Mitchell, of New York, one of the out-door physicians to Bellevue Hospital, while bathing at Asbury Park, July 18, was robbed of his gold watch and chain and a diamond ring valued at \$400.

—W. C. Hollopeter, M. D., has been elected Lecturer on Diseases of Children; and Ernest B. Sangree, M. D., Director of the Histological Laboratory in the Medicico-Chirurgical College of Philadelphia.

—Beginning with the session 1891-1892, attendance upon three regular courses of lectures will be made obligatory as a requisite to graduation at the Western Pennsylvania Medical College, Pittsburgh, Pa.

—What was said to be a genuine case of Asiatic cholera was reported from Atchison, Kansas, July 18. The patient died within twenty-four hours. The newspapers say that two physicians pronounced the case undoubtedly Asiatic cholera.

—The doctors and the druggists of southeastern New York recently had a picnic together at Orange Lake, N. Y., and Dr. J. H. Doughty, of Matteawan, read an original poem full of allusions to the work of both classes of his hearers.

—Paris gossips declare that one of the physicians who was most conspicuous in ridiculing Dr. Brown-Séquard's "elixir" has just been cured of paralysis by its administration, and is now as zealous an advocate of Séquard as he was previously a scoffer.

—Dr. John E. Ensell, a graduate of the College of Physicians and Surgeons of New York in 1872, attempted suicide in New York, July 15, by shooting himself. The wounds were fatal. It is stated that of late he has been betting on horse races and had lost heavily.

—It was reported from San Antonio, Texas, July 17, that Mr. Warren Garnet, who had returned from the State of Coahuila, Mexico, said that the deaths at Coahuila from small-pox averaged 400 for the last three months, and new cases were reported daily.

—Dr. Edward G. O'Malley, of Wilkes-barre, Pa., a graduate of the University of the City of New York, in 1881, was killed at Aspen, Colorado, July 19, by being thrown from a horse. He was at one time Coroner of Luzerne County, and was thirty-three years old.

—Dr. James D. Strawbridge, a graduate of the Jefferson Medical College, died suddenly at his home in Danville, Pa., July 19, at the age of 66 years. He served in the war for the Union, was medical director of the Eighteenth Army Corps, and spent three months in Libby prison.

—Passengers arriving in New York on the steamer Orbisonia, from Havana, July 16, stated that yellow fever of a violent type was raging in that city. They said that fifty cases a day were reported, and foreigners were leaving as fast as they could get away. The weather was very hot.

—The increase of insanity in Berlin has made it necessary that a new public lunatic asylum should be established. The building, which is to accommodate 1,000 patients, will be situated in the easterly suburb of Lichtenberg. The city of Berlin already maintains an asylum with about 1,200 inmates at Dall-dorf.

—Dr. Joseph Taylor, a cousin of the late Bayard Taylor, of Kennet Square, and

of Dr. J. Howard Taylor, of Philadelphia, died suddenly at Atlantic City, N. J., July 18. He had been ill with what seemed to be obstruction of the bowels for five days; but had no idea he was so near his end. Dr. Taylor was a retired army surgeon.

—It was recently announced from Boston that the scheme whereby all the soda water and beer apparatus interests in the United States were to be amalgamated into a trust and sold to English capitalists has fallen through, the broker who was engineering the deal having cabled from London his failure to organize the necessary combination there.

—Dr. R. C. Word, a prominent physician of Georgia, died July 20. He occupied the position of Professor of Physiology in the Medical and Dental Departments of the Southern Medical College in Atlanta, and was for many years associate editor of the *Southern Medical Record*. He was graduated at the University of the City of New York in 1846.

—Water was allowed to flow through the new New York aqueduct July 15. The water will be allowed to flow through for six weeks, when it will have to be shut off to complete the work. It is expected that the three city reservoirs will be filled. Meantime one gate admitting the water to the houses in the city will be left open. Twenty-five million gallons of water an hour are flowing through the aqueduct.

—The "Nurses' Beneficial Association," for nurses who are registered at the Directory of the College of Physicians, Philadelphia, was organized in June, 1890. There are now nearly 200 members of the association. Its object is to pay sick benefits while a nurse is disabled by reason of illness, and a death benefit to defray funeral and other expenses in case of death. It is proposed to raise \$5,000 to endow a bed in some hospital to be used for any member of the association needing it.

—A letter was received by the Board of Health of Philadelphia, July 17, from the United States Consul at Gibraltar, saying that the British steamer Sylvia, from Marbella for Philadelphia, left Gibraltar without having her bill of health from the United States Consular agent at Marbella endorsed at Gibraltar. The Consul reported good health at Gibraltar and immediate vicinity, but quarantine, he said, continued to rule at that post against arrivals from Spanish ports east of Gibraltar.

—It is reported that an extraordinary child was recently found by a correspondent of the *Lancet* in West Cornwall, Great Britain. He is now five years and six months old and is of the following dimensions: Height, four feet; weight, 117 pounds; circumference of abdomen, 42½ inches; waist, 37½ inches; chest, 37 inches; neck, 14 inches; head, 22½ inches; thigh, 23 inches; calf, 15½ inches; arm, 11¼ inches; forearm, 16½ inches. He is very healthy, eats all day long, if he can get it, and is fairly intelligent. The parents and their other children are of ordinary size.

OBITUARY.

H. H. LONGSTREET, M. D.

Dr. Henry H. Longstreet, one of the oldest and most prominent physicians in Burlington county, died at his home at Bordentown, N. J., July 6, 1890, after a brief illness. He had been in failing health for more than a year but had been confined to his home only a few days prior to his death. He was born in Monmouth county, N. J., January 11, 1819. His early education was obtained at Lenox Academy, Massachusetts. He began the study of medicine under the tutelage of Dr. Robert Cook, of Holmdel, and Prof. J. B. Beck, of New York City. In 1842 he was graduated from the College of Physicians and Surgeons of New York, and at once began the practice of his profession in Bordentown, N. J. Possessed of a vigorous physique, indomitable perseverance and social qualities of a rare order, he rapidly grew in public favor and esteem and made for himself a name and position that stood unchallenged for nearly half a century. Identified as he had been for many years with all important movements connected with the progress of the city, his loss will be felt in the community as that of few individuals. During the past two years failing health rendered it necessary for him to practically withdraw from the active duties of his profession, his partner, Dr. Wm. H. Shipps, for many years his professional associate, succeeding to his practice.

At the time of Dr. Longstreet's death he was a member of the American Medical Association and other medical societies, as well as a director of the Bordentown Banking Co. and of the Bordentown Water Co., and a member of the Board of Health.

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